Authorization to Duplicate Protected Health Information

Please complete the form below to request copies of patient X-rays and/or records from Willamette Dental. Secure electronic transfer of records is available free of charge. Printed copies incur fees as outlined below. Applicable payment is due at the time of request. Duplication of records will be processed promptly upon receipt of request and payment, if applicable. Persons over age 18 must sign this authorization for themselves. Thank you!

Who is submitting this request?

❑ Patient/Member ❑ Parent

❑ Other Authorized Requestor. Describe: _____

Which patient/member's information are you requesting?

Name:	DOB:

Which information would you like to request?

Information Available	**Secure Electronic Transfer**	**Printed / Hard Copies**
Treatment notes / perio charting	❑ No charge	❑ $10
X-Rays	❑ No charge	❑ $10
CBCT scans	N/A	❑ $10
Orthodontic models	N/A	❑ $40

Describe information requested (if necessary): _____

For Secure Electronic Transfer		
Please submit this completed form as an attachment in a secure email to adminrecords@willamettedental.com. Instructions on how to use our secure email can be downloaded from: https://wdglink.com/secure-email-instructions. **Where Would You Like These Sent?**		
Name:	Phone:	Email:

Form continues on next page…

For Printed / Hard Copies – Choose One of the Options Below		
❑ Pick-up printed copies at local Willamette Dental office. Preferred office:		
❑ Via U.S. Mail to:		
Name:		
Address:		
City:	State:	Zip:
Phone:		
Please submit this completed form and payment via mail to: Willamette Dental, ATTN: Records Department, 6950 NE Campus Way, Hillsboro, OR 97124		

I authorize Willamette Dental Group, P.C.; Willamette Dental Insurance, Inc.; Willamette Dental of Washington, Inc.; and/or Willamette Dental of Idaho, Inc., as applicable, to duplicate, use or disclose my protected health information as described above. Authorization will expire in 90 days unless I revoke it earlier by written request sent to Willamette Dental Group, P.C.; Willamette Dental Insurance, Inc.; Willamette Dental of Washington, Inc.; and/or Willamette Dental of Idaho, Inc., as applicable. The patient/member, parent or authorized personal representative must sign this Authorization.

_____ _____ _____

Signature Print Name Date