RECORDS RELEASE FOR PATIENT TRANSFER

We are sad to see you leave! If for any reason you were unhappy with the services provided for you at our office, please ask to speak with a member of our team or Dr. Jasper. We strive to provide our patients the very best dental care and your feedback helps to make our team better.

Please provide us with the reason for leaving us:

____ I have moved. In that case, enjoy your new adventure.

____ My insurance has changed. Call us and we may be able to help.

_____ I am unhappy with the dental care at Jasper Dentistry. Give us a chance to remedy the situation.

RELEASE FROM: Michele M. Jasper, DDS, 2752 Pleasant Road, Suite 106, Fort Mill, SC 29708

Telephone: (803)548-4353 Email: info@jasperdentistry.com

The facility listed above is authorized to release the requested dental/health information.

NAME OF THE PATIENT WHOSE INFORMATION IS TO BE RELEASED (one form for each family member):

PATIENT NAME_____ _____ _____

FIRST **MIDDLE/MAIDEN** **LAST**

PATIENT ADDRESS: _____ **DATE OF BIRTH:**_____

Street Address/PO Box, City, State, Zip Code

Please provide phone numbers in the event that we may have questions regarding your records transfer.

HOME: _____ **WORK:** _____ **CELL:** _____

RELEASE TO:

This information may be released to and used by the individual/organizations. A separate authorization must be completed if the information being released or the purpose differs between the individuals/organizations listed below:

NAME **ADDRESS** **PHONE** **EMAIL**

*_____ *_____ *_____ *_____

***THESE FIELDS MUST BE COMPLETE TO PROCESS REQUEST**

PATIENT'S RIGHTS AND SIGNATURE:

- I understand that I have a right to revoke this authorization at any time by notifying the Records Transfer Officer of the above named organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- If the patient is a minor or is clinically unable to sign, an authorized representative may sign this authorization.
- **I hereby authorize the use or disclosure of my identifiable health/dental information as described**. I understand that if the organization authorized to receive the information is not an insurance company or other health/dental care provider, the released information may no longer be protected by federal privacy regulations.

PRINT NAME (Patient/Authorized Representative):_____

SIGNATURE: _____**DATE:**_____

If authorized Representative, please indicate relationship to patient:

_____Spouse _____Parent (if patient is under the age of 18) _____Guardian _____ Executor of Estate

Records/current radiographs will be transferred as indicated above in accordance with South Carolina State Dental Board Regulations.