PATIENT REQUEST OF DENTAL RECORDS

RE: Patient request of dental records

I, ________________________________ hear by authorize Dr. ____________________ to release my dental records to Allan L. Bergano, D.D.S, P.C. I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand by signing this request, I will be disclosing my private health information to the above dentist.

________________________________ (Patient name)

________________________________ (Relationship to patient)

________________________________ (Signature)

________________________________ (Date)

Please forward dental records to the following address:

Allan L. Bergano, D.D.S., P.C.
4460 Corporation Lane Suite 190
Virginia Beach, VA 23462
smile@albergano dds.com

If there are any questions concerning this request, please contact our office at (757) 497-2988.