Montgomery County Department of
Health and Human Services

AUTHORIZATION TO RELEASE/RECEIVE INFORMATION

To request a copy of your dental record and/or dental x-rays please complete the information below and return, in person, to any dental clinic or email your request to DENTALRECORDSREQUEST@MONTGOMERYCOUNTYMD.GOV. Records may be picked up or emailed 30 days from the date of the request. Photo ID must be presented when picking up dental records in person.

DENTAL PROGRAM – CLINIC LOCATION

☐ ROCKVILLE ☐ SILVER SPRING-FENTON ☐ GERMANTOWN ☐ METRO COURT ☐ DENNIS AVE

Please print all information. Use a separate form for each person or agency with which information may be shared.

Last Name	First Name	Middle Initial	Date of Birth	Sex ☐M ☐F

1. The Dental Program of the Montgomery County Department of Health and Human Services (DHHS) has my permission to:

☐ **Send to** ☐ **Receive from** ☐ **Verbally discuss the information checked below with:**

Agency/Individual:_____

_____

Address:_____

Email Address:_____ **Date of Records: From**_____ _____

2. ***Initial all items covered by this release.***

_____**Acknowledgment of receipt of services**

_____**Complete Dental Record** (includes medical history, progress notes, lab slips, referrals)

_____ **Dental Radiographs and/or Images** (X-rays, pictures)

_____ **Both** (Dental record and radiographs and/or images)

3. Reason this information is being shared

☐ Dental Provider ☐ Medical Provider ☐ Legal ☐ Personal ☐ Other _____

4. I wish to request a copy of my dental information using the following method(s):

☐ I will pick up a copy of the dental record in person. I am aware that I will need to present a photo ID.

☐ I request a copy of the dental records be e-mailed directly to me at the e-mail address above.

☐ I request a copy of the dental records be e-mailed to my provider, using e-mail address provide.

5. This authorization is valid (*Check only one-not to exceed one year*)

☐ until_____(date) ☐ for 90 days ☐ until these conditions are met: _____

6. I understand I can revoke this authorization at any time by submitting a request in writing to DHHS program staff. The revocation will become effective on the date it is received by DHHS and does not apply to information that has already been used or disclosed through this authorization. DHHS may not condition treatment, payment, enrollment or eligibility for services/ benefits based on whether I sign this authorization, unless authorization is required to determine eligibility for services/benefits. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to federal or State privacy laws, this information may no longer be protected and could be disclosed.

_____ _____

Signature of patient **Date**

_____ _____

Signature of parent, guardian, or other authorized person **Date**

_____ _____

Signature of DHHS staff member **Date**