Submit by Email Print Form

Eagle Creek Children's Dentistry
6820 Parkdale Place Suite #117
Indianapolis, Indiana 46254

(317) 329-7373

Authorization for Release of Dental Records and X-rays

Introduction: In accordance with Indiana Law related to the release of dental records, it is the policy of this office to transfer the records of the patient to either the new dentist or the patient upon receipt of written request. The original records will remain the property of Eagle Creek Children's Dentistry. Payment is required to cover the cost of duplication and/or copying patient records. This payment must be provided in the form of cash or credit card. Once payment is provided, the records will be duplicated within 3 days of receipt of the payment. In compliance with the Health Insurance Portability and Accountability Act (HIPAA), governmental identification must be presented before the records are released. Release of the records are limited to the new dentist or the patient; records will not be released to other individuals (unless the patient is a minor child).

Charge: If you request your full set of x-rays only, the charge for duplication is $35.00. If you request both your dental records and treatment notes, the cost for duplication is $45.00. We kindly request that you provide either cash or credit card. Checks cannot be accepted. For your convenience, a credit card authorization form is included. This payment must be provided before we can duplicate records.

Outstanding Balances: The release of your dental records does not negate any outstanding balances on your account. You are still responsible for that balance and legal action will be pursued to collect that balance. You will be responsible for the balance as well as collection and legal costs associated with collecting the debt.

Dental Records Release Form

I, (print patient or guardian name)_____, hereby authorize the doctor and staff of Dover Family and Cosmetic Dentistry to release records or knowledge concerning my dental health to (select one):

_____ 1. Given directly to me
_____ 2. Sent directly to a dental office (postage fee will apply)

Name of Dental Practice: _____
Address: _____
Telephone Number: _____
E-mail:_____

_____ 3. Given to a guardian (if patient is a minor)

I am requesting that you release the following (check 1 or both):
1. _____ all x-rays 2. _____ all treatment notes

Please complete this form and bring it to our office or fax it to (317) 735-161. Please be aware that payment must be rendered before the records will be duplicated. The fee is $35.00 for x-rays only and $45.00 for x-rays and treatment notes. If you are faxing the form, please complete the credit card authorization form. Once the payment is applied to your account, the receipt will be attached to the duplicated records. You may then pick up the records from our office (a government issued ID must be presented). It is advised that you call our office first (317-329-7373) to ensure the records were duplicated. Upon request, the records can be mailed or e-mailed to your new dentist. **The records will only be released to another individual in the event that the records belong to a minor child.**

Agreement to Debit My Credit Card for Records Transfer

I give Eagle Creek Children's Dentistry permission to debit

_____ 1. $45.00 for x-ray and treatment notes _____ 2. $35.00 for X-ray only from the below listed card. Please apply these funds to the account of:

Patient Name: _____ (print clearly)

Responsible Party Account:
_____
I understand that these funds are for the cost of duplicating, copying and mailing the dental records for the above name patient. In the event that there are any problems with my credit card payment, I understand the records will not be released until the problem is resolved. **I understand that although the records were released, I am still responsible for all outstanding balances on the account. Legal action will be pursued to collect this debt.**

Name on Card:
_____
Credit Card Number:
_____
Circle One: **Visa Mastercard Discover**
Credit Card Expiration Date:
_____
Card Verification Code (last 3 digits on back of card): _____

I certify that this is my credit card and I am legally authorized to give permission for its use. By completing and signing this agreement, I hereby give my fully informed consent to duplicate the records for the above named patient.
I understand that once the services have been completed and the payment has been applied, I will not be entitled to any refunds. I agree not to dispute resultant charges.

Cardholder Signature: _____ Date: _____
Cardholder Printed name: _____