



## IMMEDIADENT RECORDS RELEASE FORM

### CONSENT TO COMMUNICATE PROTECTED HEALTH INFORMATION BY EMAIL

I expressly permit ImmediaDent to communicate my Protected Health Information ("PHI") via email to the e-mail address indicated on my patient registration form, patient record, and this Records Release Form. PHI includes all individually identifiable health information, including demographic data, medical histories, test results, insurance information, and other information gathered, generated, or used by ImmediaDent to identify a patient, provide healthcare services, or determine healthcare coverage. This release also applies to any e-mail that ImmediaDent may send to my referring or subsequent dental/medical providers which may contain my PHI.

### E-MAIL RISKS AND YOUR RESPONSIBILITY

If you agree to permit ImmediaDent to use e-mail to communicate your PHI, you should be aware that the internet is not secure or private, and unauthorized people may be able to intercept, read and possibly modify the e-mail sent by ImmediaDent.

### ACKNOWLEDGMENT AND AGREEMENT

ImmediaDent will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, we cannot guarantee that e-mail will be confidential. Additionally, ImmediaDent will not be liable in the event that you or anyone else inappropriately uses or accesses your e-mail or otherwise misuses your PHI or other sensitive information.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of e-mail between ImmediaDent and me, and consent to the conditions set forth in this Records Release Form. Any questions I may have had were answered. I understand that this consent is valid for one-year from the date below or until such time as I revoke the consent in writing to ImmediaDent. The revocation of this consent will not have any effect on any information released before revocation, including any action taken by the individual or entity that received the protected health information pursuant to your consent.

**Your signature on this form indicates you are giving permission for ImmediaDent to provide your PHI to the person or entity named below. Absent clear prior written instructions otherwise, all PHI in the possession of ImmediaDent will be provided to the person or entity named below.**

**All fields must be completed below to release records.**

Records Requested:      X-Rays                      Clinical Notes                      Statement/Ledger  
   Treatment Plan

Patient information and signature:

Patient Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Person or Entity to whom your records may be provided:

Printed Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Please email the completed form to [billing@immediadent.com](mailto:billing@immediadent.com).