tiny teeth
PEDIATRIC DENTISTRY

Tiny Teeth Pediatric Dentistry, LLC
3933 N. Maize Rd, Suite 200
Maize, KS 67101

**Authorization for Release of Dental Records and X-rays**

**Introduction**: In accordance with Kansas Law related to the release of dental records, it is the policy of this office to transfer patient records to either the new dental office or the patient/parent/legal guardian upon receipt of written request. The original records will remain the property of Tiny Teeth Pediatric Dentistry, LLC. Payment is required to cover the cost of duplication and/or copying of the patient records. This payment must be rendered in the form of cash or credit card. Once payment is received, the records will be duplicated within 3 days of the receipt of the payment. In compliance with Health Insurance Portability and Accountability Act (HIPPA), governmental identification must be presented before the records are released. Release of 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 or by court order).

**Charge**: The fee for record duplication is $25.00. This fee is only charged if you are requesting a copy of the written record and payment must be received before we can duplicate records. If you are only requesting we release x-rays, **we do not charge a fee to email x-rays to the new dental office**.

**Outstanding Balances**: The release of your child's dental records does not negate any outstanding balances on your account. You are still responsible for that balance. If needed, 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 name of parent/guardian)_____, hereby authorize the doctors and staff of Tiny Teeth Pediatric Dentistry, LLC to release records or knowledge concerning the dental health of my dependent, (print child's/children's name)_____.

Please select one:

____1. I would like the records given directly to me and will pay the $25 release of records fee

____2. I would like the records duplicated and sent directly to a dental office.

Name of dental office: _____

Telephone number: _____

Office email address: _____

If requested, the records can be mailed to your new dentist. Please provide address below:

_____

**____3. I do not want to pay the $25 fee for the written records to be duplicated and request that current x-rays be sent to the new dental office.**

Name of dental office: _____

Telephone number: _____

Office email address: _____

I am requesting that you release the following information: _____

_____

_____

By completing this form, you acknowledge that payment must be received prior to record duplication. Once payment is applied to your account, we will attach a receipt to your records. Our office will contact you within 3 business days of receipt of payment and this form to let you know your records are ready to be picked up (if you selected that option). You will be required to present a government issues ID at time of pick up. The records will only be released to another individual in the event that the records belong to a minor child or by court order. **It is advised that you contact our office first at 316-202-0140 to ensure we have received the release form; payment has been posted to your account and to verify that we have the duplicated ready for pick up.** By completing and signing this agreement, I hereby give my fully informed consent to duplicate the records for the above listed patient/patients.

Signature: _____ Date: _____