Authorization to Duplicate, Use or Disclose Protected Health Information

Willamette Dental Group

Please complete the form below to request copies of patient records and/or X-rays from Willamette Dental Group. Secure electronic transfer of records is available free of charge. Printed copies incur fees as outlined below. Applicable payment is due at the time of request. Duplication of records will be processed within 14 days of receipt of request and payment, if applicable.

Who is submiting this request?

- ☐ Patient/Member
- ☐ Parent
- ☐ Other Authorized Requestor. Describe: _____

What information would you like to request?

Information Available	Secure Electronic Transfer	Printed / Hard Copies
☐ Treatment Notes / Dental Chart	No charge	$10
☐ X-Rays – Traditional	N/A	$10
☐ X-Rays – Digital	No Charge	$10
☐ Ortho Models	N/A	$30

Describe information requested (if necessary): _____

Which patient/member's information are you requesting?

Name:	DOB:

Where would you like records sent?

Name:		
Address:		
City:	State:	Zip:
Phone:		
Email:		

How would you like records sent?

- ☐ Via secure electronic transfer. To submit, email this completed form to Willamette Dental Group via our secure email by clicking here. Click here to download instructions on how to use our secure email.
- ☐ Pick-up at printed copies at local WDG office. At which office would you like to pick-up? _____
- ☐ Via U.S. Mail. To submit, mail this completed form and payment to:

  Willamette Dental Group
  ATTN: Records Department
  6950 NE Campus Way
  Hillsboro, OR 97124

I authorize Willamette Dental Group P.C. to duplicate, use or disclose my protected health information as described above. Authorization will expire in 90 days unless I revoke it earlier by written request sent to Willamette Dental Group P.C. The patient/member, parent or authorized personal representative must sign this Authorization.

Signature _____ Print Name _____ Date _____

FOR INTERNAL USE – Completed by: