All Seasons Dental, Inc.
2208 Thatcher Ave
Pueblo, CO 81004
(719) 545-3838
allseasonsdentalco.com

Authorization for Release of Dental Records and Radiographs

In accordance with Colorado law (3 CCR 709-1) all original records remain the property of All Seasons Dental, Inc. but patients are entitled to access to copies of all records within a reasonable time from the date of the signed request, normally not to exceed five days, excluding weekends and holidays. We will make every effort to make your records available in a timely manner; however, same day requests for records may not be possible.

Also, in accordance to the Colorado State law, "The patient or representative shall pay for the reasonable cost of obtaining a copy of the patient record. Actual postage costs may also be charged." In addition, if a patient requests copies of radiographs or other items, the dental office may charge "the actual cost of such reproduction." We have carefully calculated the cost of printing your treatment notes and processing your radiographs. We will make an effort to minimize the number of sheets of radiographs whenever possible. Payment is required before we can process your request. Costs are as follows:

- $12.00 for the first ten or fewer pages and $0.25 per page for every additional page (per state regulations)
- $5.00 per sheet of radiographs

As a courtesy to you, All Seasons Dental, Inc. will absorb the cost of postage since it is nearly impossible to calculate it ahead of time.

I, (Print Patient or Legal Guardian Name Here)_____, hereby authorize the doctors and staff of All Seasons Dental, Inc. to release copies of:

☐ Current Dental Radiographs ☐ All Dental Radiographs ☐ Radiographs from (Date): _____

☐ Treatment Notes ☐ Treatment Notes for Tooth #: _____

☐ Periodontal Charting

☐ Other (Please Specify): _____

To the following:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: (_____)_____

Patient/Parent/Guardian Signature: _____ Date of Birth: _____

Social Security or Driver's License/State Issued ID Number: _____ Date of Request: _____

OFFICE USE ONLY

I certify the patient or legal representative listed above:

☐ Filled out and signed the records release form.

☐ Paid $ _____ for an estimated (#) _____ pages of treatment notes + (#) _____ pages of radiographs. Payment was made by : ☐ Cash ☐ Check ☐ Debit or Credit Card

Signature of Office Staff: _____ **Date:** _____