TGS ENDODONTICS (a/k/a TISSURA, GREGORY & SHAPIRO, P.C.)
RELEASE OF YOUR PHI - SUCH AS DENTAL TREATMENT RECORDS AND/OR DIGITAL X-RAYS INSTRUCTIONS

****If you would like copies of your PHI such as your dental treatment and/or x-rays to be released to you or to someone else, please read the following instructions.**

You may request an Authorization for Release of Protected Health Information (PHI) for copies of your dental treatment records and /or x-rays at any time. Our office staff will gladly furnish you with a copy of such Authorization.

We only request that you read and follow these instructions to avoid delays.

The Business Manager/Privacy Official reviews all records transfers before the office releases them. Please ask to speak to our Business Manager/ Privacy Official if you have any questions. We really do care about our patients, both past and present, and protecting our patients against harm is an important duty. Identity theft and other criminal activities seem to be on the increase and, in an attempt to protect our patients, we are requiring patient's **governmental identification** before releasing copies of any patient records and/or digital x-rays. Under HIPAA Omnibus, we must have procedures in place to help us verify a patient's identity.

Acceptable government issued identification are a current Georgia Driver's license, a current Georgia ID card or a current US Passport. Current out of state licenses will be usually accepted. Most patients use a current Georgia Driver's license. Please **make a copy of both the front and back of your Georgia Driver's license** and mail it along with your Authorization for Release of Protected Health Information (PHI). Of course, we prefer for you to personally come in and sign the Authorization for Release of Protected Health Information (PHI) but we know that this is not always possible. We must point out to you that faxing or unencrypted emailing your information is unsecure and not recommended by us. We cannot secure information which is faxed or emailed (unencrypted) to us.

Please, **do not walk into the office without notice.** We may not be able to leave scheduled patients to duplicate records. We owe the patients who are in our office being treated the courtesy of attending to their care. It usually takes from **three days to a week** to have records duplicated and another three to seven days for the US mail to get to you. Records are NOT duplicated on Mondays, Tuesdays or Thursdays.

Depending on who is making the request for release of the patient's protected health information (PHI)and to whom we are releasing the patient's PHI, we are permitted to charge costs of copies, cost of labor for copying information requested (whether in paper or electronic form), costs of mailing patient's record, supplies for creating the paper copies, or for electronic media if patient asks for a copy on portable media (such as a CD-ROM or USB drive), certification fee(s) and other direct administrative costs. Labor costs may include skilled technical staff time spent to create and copy an electronic file, such as compiling, extracting, scanning and burning the information to electronic media, and distributing the media. We suggest that you contact our office about the fees. **Under the HIPAA Privacy Rule and under Georgia state law, we are allowed to require payment of the above fees prior to furnishing you copies of the patient's PHI.**

If you want your Doctor to prepare a written summary or explanation of your dental record and/or x-rays, there will be additional fees to cover his/her time and effort. Should you wish your Doctor to prepare a written summary or explanation of your dental record then you and your Doctor will **both** need to agree **in advance** 1) that it is all right for the Doctor to give you a summary or explanation and 2) to the fee for writing the summary or explanation. This fee will need to be paid **prior** to the written summary or explanation being provided to you. Make sure your Authorization for Release of PHI which you submit to us allows your Doctor to release a written summary or explanation of your dental record to you or to a third party.

Please contact our Business Manager/ Privacy Official at 404-256-4772 for any further questions you may have.

(TGS Revised 2/5/2014)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)
(For release of copies of PHI to patient or to third party)

****INSTRUCTIONS: Make sure all blanks are filled in. Failure to do so may prevent or delay release of information.**

Patient ID: Patient's Name: _____ **PT'S SOCIAL SEC#:** _____ **Pt's DOB:** _____

Patient's address: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

Pursuant to HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R Sections 164.512 & 164.508, I hereby authorize the doctors and staff of TGS ENDODONTICS to release copies of my protected health information as requested below with respect to any dental care and treatment while I was your patient to the following individuals or organizations:

Name & Address where you want the information sent.

Name: _____ **Relationship to Patient:** _____

Street Address: _____

City, Zip Code: _____

Telephone #:
(BUSINESS) _____ **(CELL)** _____ **(HOME)** _____

Name or Contact Person: _____ **(PHONE #)** _____

I understand that the type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognosis and copies of any and all other records, including digital x-rays(if requested), alcohol or drug abuse, mental problems or HIV/AIDS which pertain to me. **I understand that I may revoke this authorization at any time by notifying TGS ENDODONTICS in writing. However, the revocation will not have an effect on any actions TGS ENDODONTICS took before it received the revocation.**

Unless otherwise revoked, this authorization will expire 6 months from date of signature, or when the following event occurs:

_____

I request that you release copies of my health care information by item(s) I have checked:

- ☐ **Digital x-ray(s)**
- ☐ **Treatment notes**
- ☐ **Financial records**
- ☐ **Other (describe)** _____

Check following if requesting Certification of COPIES:

- ☐ ***I am herby authorizing and requesting CERTIFICATION OF COPIES of my HEALTH CARE INFORMATION which I marked by placing a check by requested item.***

The purpose of this authorization is (check all that applies):

- ☐ **At the request of the individual or legal representative**
- ☐ **Administration of a Disability claim**
- ☐ **Administration of a Worker's compensation claim**
- ☐ **Subpoena or other legal process**
- ☐ **Other (describe):** _____

The dates of records to be disclosed from _____ **(mm/dd/yyyy) to** _____ **(mm/dd/yyyy)**

I HEREBY AUTHORIZE THE DOCTORS & STAFF OF TGS ENDODONTICS TO RELY UPON A PHOTOCOPY, ELECTRONICALLY SUBMITTED COPY OR FACSIMILE COPY OF THIS AUTHORIZATION. I understand that I may see and copy the information described on this form if I ask for it, and that I may receive a copy of this authorization after I sign it.

The Patient, Guardian and/or Personal Representative must complete the rest of this form. If Authorization signed by someone other than patient, the following is a description of representative's authority to act for the patient (The person acting for the patient will need to give us a copy of document(s) which gives them the legal authority to act for patient which, after review , we may either accept or deny):

_____

If the request is by a patient:

Date: _____

_____ _____

Signature of Patient **Print Name of Patient**

If the request is by a legal guardian or a patient's personal representative:

Date: _____

_____ _____

Print Name of Legal Guardian/Personal Representative **Relationship to Patient, including authority to act as representative**

☐ **I certify that I have the legal authority under federal and state laws to make this request on behalf or the patient identified above.**

_____ _____

Signature of Legal Guardian/Personal Representative Date:

A copy of this authorization has been requested and received:

◯ **Yes** ◯ **No**

Please complete this form and mail or bring it to us. If you are faxing it to us, please call prior to faxing the completed form to make sure a member of our staff is available to securely receive the fax. You may also email it to our Privacy Official, Marge Shapiro, at margedshap@hipaa-compliant-forms.com which is a HIPAA compliant encrypted email address. Caution: there is some level of risk that third parties might be able to read unencrypted emails or faxed documents. The best means of sending information is through the mail or by personally delivering it to us.**

Depending on who is making the request for release of the your protected health information(PHI)and to whom we are releasing your protected health information, we are permitted to charge costs of copies, cost of labor for copying information requested (whether in paper or electronic form), costs of mailing patient's record, supplies for creating the paper copies, or for electronic media if patient asks for a copy on portable media (such as a CD-ROM or USB drive), certification fee(s) and other direct administrative costs. Labor costs may include skilled technical staff time spent to create and copy an electronic file, such as compiling, extracting, scanning and burning the information to electronic media, and distributing the media. We suggest that you contact our office about the fees. Under the HIPAA Privacy Rule and under Georgia state law, we are allowed to require payment of the above fees prior to furnishing you copies of the patient's requested dental health information.

There will be an additional fee for certification of each document which you authorize and request.

The above fees do not include the Doctor's written summary or explanation of your dental record.

Please contact our Privacy Official, Marge Shapiro, in order to obtain the fees.

In accordance to Georgia law all original records remain the property of TGS ENDODONTICS but patients are entitled to access copies of all records. (GA Code 31-33-2)

Our Office Policy is to attempt to verify identity prior to releasing your PHI. We are sorry for any inconvenience. But we feel it is necessary to help us protect your PHI.

Please contact our Privacy Official, Marge Shapiro, if you have any questions. She can be reached by email at margedshap@hipaa-compliant-forms.com (which is a HIPAA compliant email address) and at the following address and telephone numbers:

TGS ENDODONTICS (a/k/a TISSURA, GREGORY & SHAPIRO, P.C.)

5555 PEACHTREE DUNWOODY ROAD, SUITE 275

THE MEDICAL QUARTERS, SANDY SPRINGS, GA 30342

OFFICE PHONE: (404) 256-4772

FOR DENTAL OFFICE USE ONLY

☐ **Request for access denied (attach written denial).**

☐ **Request for access approved.**

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

(Rev 2/7/2014)