Authorization to Transfer or Forward Dental Records

I,_____DOB___/____/_____(Patient – please print), hereby authorize Dr. James R. Bashaw or his agent to transfer or forward copies of requested records of individual identifiable health information relating to me and or my dependents, which is also called "protected health information" under HIPAA's Privacy Rule, by personal delivery, mail, fax, or e-mail to me personally, or to my new dentist listed below. Please specify one. Forward to my personal email:_____

Dependents:_____

Address_____

_____Phone:_____

or forward, in like manner, a copy of requested records to my new dentist indicated below. I understand that, in the absence of an alternative designation, my records will be maintained by Dr. James R. Bashaw or his agent for a period of 5 years from my last visit to his office. My new dentist is: _____ and is located at:

_____

_____Email:_____Phone:_____

Most requested records are for current x-rays only, but other records may include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, treatment models, and other related materials.

The undersigned acknowledges that information sent by fax and e-mail will not be encrypted and thus could be read by an unauthorized third party and that James R. Bashaw, D.D.S., Inc., Dr. James R. Bashaw, or his agents are not responsible for any unauthorized access to the information while in transmission, and have no obligation to safeguard the information once received by the recipient.

I understand that I may revoke this authorization at any time by notifying James R. Bashaw, D.D.S., Inc., Dr. James R. Bashaw, or his agents in writing and that if I choose to do so, my request to revoke will not affect any actions taken by James R. Bashaw, D.D.S., Inc., Dr. James R. Bashaw, or his agents before receiving revocation.

I expressly release James R. Bashaw, D.D.S., Inc., Dr. James R. Bashaw, or his agents from any and all liability arising from compliance with this request and disclosure of the requested information.

Signed:_____(Patient or Guardian)

_____(Print Name)

Date:_____

Please send records request to:

James R. Bashaw, D. D. S.

2480 Wellington Rd.

Cleveland Heights, Ohio 44118

Or you may scan completed form and email to: bashawdds@yahoo.com