Authorization for Release of Records – Instructions for Requester

(see Form on other side)

If you DO want to transfer your records, please complete the form on the other side and return it to us. Do not return this form until AFTER your final visit in our office. This form is required to send records. We cannot send records based upon a verbal request.

If you DON'T want to transfer your records, you don't need to fill out this form, and no further action is needed.

The Healthcare Information Portability and Accountability Act (HIPAA) gives you the right to access your personal healthcare information. This office uses a combination of formats including paper, film, and digital, to record and store your information. You may request copies of any, or all, of your records maintained by us. HIPAA provides that a cost-based fee may be charged to gather, copy, scan, duplicate, compile, and send the records. The fee charged is based on staff and doctor time to do this, plus our out-of-pocket costs for materials and postage. HIPAA allows up to 30 days for us to forward copies of records.

Dr. James R. Oliver, Jr., D.D.S. is offering to accept patients of Dr. Spainhour upon office closure in November 2024.

If you want to send your records to Dr. Oliver, we will forward copies of your written treatment record and most recent x-rays securely at no charge as a courtesy to you and Dr. Oliver. If this is what you want, 1) check the box beside his name, then 2) check ONLY Records #1 AND Delivery #1.

If you want to transfer your records to a different office or person(s), we will forward a SUMMARY of recent visits and your MOST RECENT X-RAYS by secure email at NO CHARGE as a courtesy to you. If this is what you want, 1) check the box and enter who and where they should go, then 2) check ONLY Records #2 AND Delivery #1.

If you want other records types or other delivery methods, please check the appropriate items in both the Records and Delivery columns, and include a description of what you want if applicable. A fee may apply.

Sign and date the Authorization page, and return it to us via standard mail, e-mail, or in person. Only one patient per form (i.e., no 'John Smith family' on one form, but you may send multiple forms together). Date of birth is required on the form. Adult patients must sign their own form. If the patient is a minor, then a parent or legal guardian must sign. Only the patient (or other person already listed in the patient's chart on the C*onsent For Disclosure* form) may request records for an adult. Double check your information and choices. Incorrectly filled out forms will not be accepted, but we will notify you that it was filled out incorrectly and you will need to send a new form, as we cannot make any changes whatsoever on the form for you.

If any items incurring a fee are selected, we will review your records and contact you with a cost to produce and send your records. Once payment has been received, we will produce and send them. This fee may be paid by cash, check, or credit/debit card. It cannot be billed to anyone, including your insurance company.

Please keep in mind that a written summary or scanned written records are less costly to produce, and copies of x-rays are more costly to produce because of the time required. Also, e-mail is free, while flash drives and physical mail is not. So please consider whether the FREE options will serve your needs.

If you have any questions, please contact us and we'll be happy to help.

Stephen E. Spainhour, D.D.S.
8917 Fargo Road, Suite A
Henrico, VA 23229

Phone: 804-747-7001
E-mail: securemail@SpainhourDentistry.com

(Please note that e-mail sent FROM the address above is sent securely, but email sent TO it may not be secure, depending on the senders' capabilities.)

You may make copies of this form or download it from our website at www.SpainhourDentistry.com

Authorization for Release of Records

(see Instructions on other side)

SECTION A: PATIENT WHOSE RECORDS ARE BEING REQUESTED – ALL INFORMATION MUST BE PROVIDED

Name: _____

Address, City, State, Zip: _____

Date of Birth: _____ Phone: _____

SECTION B: DOCTOR or PRACTICE WHO HAS THE RECORDS BEING REQUESTED:

STEPHEN E. SPAINHOUR, D.D.S.
8917 FARGO ROAD, SUITE A
HENRICO, VA 23229

SECTION C: WHERE THE RECORDS SHOULD BE SENT (CHECK the appropriate box):

☐ Dr. James R. Oliver, Jr., D.D.S.
Evolve Dental Care
8921 Three Chopt Rd, Suite 304
Henrico, VA 23229

☐ Name _____
Address _____
City _____ State _____ ZIP_____
E-mail: _____

WHAT DO YOU WANT US TO SEND, AND HOW? - Please see attached instructions, then select Records AND Delivery choice(s):

Records	**Delivery**
___ 1. ALL written treatment records and most recent x-rays, sent to **Dr. James R. Oliver, Jr., DDS** – NO FEE TO COPY	___ 1. **Encrypted email** sent to the practice or person indicated – NO FEE TO SEND
___ 2. SUMMARY of recent visits and most recent x-rays, sent to **OTHER practice or persons** – NO FEE TO COPY	___ 2. **Paper copies** mailed to the practice or person indicated – FEE APPLIES
___ 3. ALL written treatment records and most recent x-rays sent to OTHER persons or practice – FEE APPLIES	___ 3. **Paper copies** – hold for pickup at office – FEE APPLIES
___ 4. Other – please describe what you want – FEE APPLIES:	___ 4. **Digital format (flash drive)** mailed to the practice or person indicated – FEE APPLIES
	___ 5. **Digital format (flash drive)** – hold for pickup at office – FEE APPLIES

SECTION D: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose: By signing this form, you consent to the disclosure of your protected health information by the doctor, practice, or healthcare entity named in Section B, to the individuals and/or entities specified above in Section C.

Right to Revoke: You have the right to revoke this Consent at any time by giving written notice of your revocation to the releasing doctor, practice, or other healthcare entity listed above in Section B. Any revocation of this consent will *not* affect any action which was taken in reliance on this Consent before your revocation was received.

Fee for Preparation of Records: A fee may be charged to copy and send records. This fee is based on the cost of staff time to copy, scan, print, copy to flash drive, assemble, prepare and send the records. If you choose a record type and/or delivery type that incurs a fee, you will be advised of the amount of the fee prior to preparation. Once the fee has been received, the records will be prepared and sent.

SIGNATURE:

I certify that I have had full opportunity to read and consider the contents of this form. I understand that, by signing this form, I am giving my consent to the releasing doctor, practice, or other health care entity, for the disclosure of my protected health information to the individuals and/or entities specified.

Requester's Signature: _____ Date: _____

The person completing this form must sign it. If the Requester is NOT the patient, then the Requester must sign above AND complete the information below:

Authorized Requester's name (print): _____

What is your relationship to patient or legal standing to request these records? _____