Authorization for Release of Records – Instructions
(see Form on other side)

Dr. Stephen E. Spainhour, D.D.S. will be retiring on November 21, 2024.

Dr. James R. Oliver, Jr., D.D.S. is now accepting his patients.

If you DO want to transfer your records to Dr. Oliver OR anyone else, please complete the form on the other side and return it to us. 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 do anything else.

HIPAA (Healthcare Information Portability and Accountability Act) 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 out-of-pocket costs for materials and postage. HIPAA allows up to 30 days to forward copies of records.

Option 1: If you want to send records to Dr. Oliver, we will forward copies of your entire written treatment record and most recent x-rays securely at no charge. If this is what you want to do, CHECK Option #1. **NO FEE WILL APPLY**.

Option 2: If you want to send 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 to do, CHECK Option #2. BE SURE to tell us the name and email address of the intended recipient. **NO FEE WILL APPLY**.

Options 3 or 4: If you want some other combination of records and/or delivery methods, please CHECK either Option #3 or #4 as appropriate, and provide the contact information for the intended recipient. **A FEE WILL APPLY TO THESE OPTIONS**.

Sign and date the form, and return it to us via regular mail or as an e-mail attachment. 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, power of attorney, or other person already listed in the patient's chart on the C*onsent For Disclosure* form may request records for an adult.

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 card through November 26, 2024. After that date, it can only be paid by check mailed to the address below. 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 involved. Also, e-mail is free, while other delivery methods are not.

*** Please consider whether the FREE options will serve your needs. ***

Return the form by regular mail, or as an e-mail attachment:

Stephen E. Spainhour, D.D.S.
PO Box 70055
Henrico, VA 23255

E-mail: securemail@SpainhourDentistry.com

Phone: 804-525-0432 if you have questions or need help

(E-mail that we send FROM the address above is encrypted, but email that you send TO it may not be encrypted, depending on your platform's capabilities.)

You may make copies of this form or print 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.
PO BOX 70055
HENRICO, VA 23255

SECTION C: WHAT RECORDS DO YOU WANT, SENT TO WHOM, & HOW SHOULD THEY BE SENT – Check ☑ desired option(s):

☐ 1. **ALL WRITTEN TREATMENT RECORDS and most recent x-rays, sent to DR. JAMES R. OLIVER, JR., DDS – NO FEE**

☐ 2. **SUMMARY OF RECENT CONDITIONS AND TREATMENTS** and most recent x-rays, sent electronically to **OTHER** practice or persons as indicated below – **NO FEE:**

Name and EMAIL ADDRESS: _____

☐ 3. All written treatment records and most recent x-rays, sent electronically to OTHER practice or persons as indicated below – **FEE APPLIES:**

Name and EMAIL ADDRESS: _____

☐ 4. SOME OTHER COMBINATION of records and method of delivery to OTHER practice or persons – PLEASE DESCRIBE in the space below, WHAT you want us to send, WHO we should send it to, and HOW you want it to be sent - **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 doctor and staff time and out-of-pocket expenses to copy, scan, print, assemble, prepare, and send the records. If you choose an option 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? _____

Revised 11/08/2024