Request for Access to Patient Health Records

Dr. Linnea Westerberg
990 Sonoma Ave. Ste. 16
Santa Rosa, CA 95404
(707) 571-7890
(707) 571-7908 (Fax)
lwesterberg@yahoo.com

Instructions: Please complete and send back to our office. You may request a copy of this completed form.

Patient Name:

____

Requested by: ☐ Patient ☐ Parent/legal guardian ☐ Personal representative of the patient

If requestor is not the patient, print full name, address and telephone number of the requestor:

____

____

____

____

I request: *(check one only; complete another form for each additional request)*

☐ Inspection of requested patient record.

☐ A copy of requested patient record **(VIA STANDARD MAIL)**: ☐ for myself ☐ to be sent to another

Name & Address: ____

____

☐ Please send requested patient record via unencrypted email. I recognize that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties.

Email address: ____

Any and all information may be released including, but not limited to, mental health records protected by the Lanterman-Petris-Short Act, drug and/or alcohol abuse records and/or HIV test results, if any, except as the patient has specifically provided below:

____

____

I hereby authorize this dental practice to release information contained in the health record of *(patient name)*

______________________________________ as described on this form.

Signature: ____