

**Atlanta Dental Group PC**  
1634 Piedmont Avenue, NE  
Atlanta, Georgia 30324  
Voice (404) 874-7428 Fax (404) 873-2231  
www.atlantadentist.com

## *Authorization for Release of Dental Records and X-rays*

I, ( print patient or guardian name ) \_\_\_\_\_, hereby authorize the doctors and staff of the Atlanta Dental Group PC to release records or knowledge concerning my dental health to:

Full Dr. Name \_\_\_\_\_

Street Address \_\_\_\_\_

City, Zip Code \_\_\_\_\_

Practice telephone number: \_\_\_\_\_

I specifically request that you release copies of:

“ all x-rays      “ all treatment notes

Signed ( patient or guardian name ) \_\_\_\_\_

Printed name ( patient or guardian name ) \_\_\_\_\_

Please complete this form and fax it to (404) 873-2231. Payment is required to cover the cost of duplication and/or copying patient records. In accordance to Georgia law all original records remain the property of the Atlanta Dental Group PC but patients are entitled to access to copies of all records. ( GA Code 31-33-2 )

## Records Transfer Instructions

[ Please read carefully in order to avoid delays. ]

The **Financial Manager** handles all records transfers. In order to insure that your personal records transfer goes well, please limit your conversations to the Financial Manager. She is the best person to take care of you. Talking to several people only confuses things.

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 **governmental identification** before releasing any patient records. Acceptable government issued identifications are a current Georgia driver's license, a Georgia ID card or a US Passport. Out of state licenses will be usually be 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 fax it along with your records transfer request. Of course, we prefer for you to personally come in and speak with the Financial Manager about transferring your records but we know that this is not always possible.

Please, **do not walk into the office without notice**. We will not leave scheduled patients who are in our dental chairs 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 the new dentist's office. Records are NOT duplicated on Fridays or Saturdays. We stay open on these days as a convenience to our patients but only half of the staff works on each of those days.

If you only check off that you need x-rays, the charge for duplication and mailing is **\$ 45.00**. If you also wish to have photocopies of your treatment sheets, the fee is **\$ 55.00**. It often takes a dental assistant about a half hour to one whole hour to duplicate records. Since this is a significant expense, your payment must accompany your request for us to dedicate a staff member to this activity.

We have included a **credit card authorization form** in this Adobe PDF. Please fill it out completely and fax it with your records transfer request.

## Agreement to debit my credit card for records transfer

I give the Atlanta Dental Group PC permission to debit

" \$ 55.00 for full records transfer      " \$ 45.00 for an x-rays only transfer

from the below listed credit card. Please apply these funds to the account of:

Patient Name: \_\_\_\_\_ ( print clearly )

Responsible Party Account: \_\_\_\_\_

I understand that these funds are for the costs of duplication, copying and mailing the dental records for the above named patient. In the case that there are any problems with my credit card payment, I agree to pay all collection costs and reasonable attorneys fees incurred in attempting to collect on this or any future outstanding account balances for the above named patient.

Name of the Bank that issued this credit card: \_\_\_\_\_

Bank Telephone Number: \_\_\_\_\_

Circle one: Visa MasterCard Discover

Credit Card Number: \_\_\_\_\_

Credit Card Expiration Date: \_\_\_\_\_

Card Verification Code \_\_\_\_\_

I certify that this is my credit card and that I am legally authorized to give permission for its use. By signing this agreement and by providing a photocopy of my credit card, I hereby give my fully informed consent to copy and mail records for the above named patient.

I realize that once the services have been completed that these funds will be applied to the payment of these services and that I will not be entitled to any refunds. I agree not to dispute the resultant charges.

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cardholder Printed Name: \_\_\_\_\_

The Atlanta Dental Group PC will keep all information entered on this form strictly confidential.