**Conejo Valley Dental Institute**
Rodney P. Burton, D.D.S.
75 Long Court   Suite 200
Thousand Oaks, CA  91360
Voice  (805) 494-1500     Fax  (805) 435-1809
Oakssmile.com

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

I, (print patient or guardian name) ___________________________________________,
hereby authorize the doctor and staff of the Conejo Valley Dental Institute
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 (please check):

- ☐ All X-Rays
- ☐ All Treatment Notes

Signed (patient or guardian Name) _________________________________________________

Printed Name (patient or guardian name) ___________________________________________

Please complete this form and fax to (805) 435-1809.  Payment is required to cover the cost of duplication and/or copying patient records.

**Records Transfer Instructions**

**(Please read carefully in order to avoid delays)**

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 California driver's license, a California ID Card, or a US Passport. Out of state licenses will usually be accepted. Most patients use a current California driver's license. **Please make a copy of both the front and back of your California driver's license** and fax it along with your records transfer request.

If you wish to pick up your records in person we will need 72 hour notice.

The charge for duplication and mailing of x-rays is $25.00. If you wish also to have photocopies of your treatment sheets, the fee is $50. 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.

**Included is a credit card authorization form. Please fill it out completely and fax with your records transfer request.**

## Agreement to Debit My Credit Card for Records Transfer

I give the Conejo Valley Dental Institute permission to credit (please check):

□ $50 for full records transfer □ $24 for 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 attorney 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 American Express
Credit Card Number: ____________________________________________________
Credit Card Expiration Date: ______________________________________________
Card Verification Code: ___________________________________________________
Billing Address of Card: __________________________________________________

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 Conejo Valley Dental Institute will keep all information entered on this form strictly confidential.