Leander Dental Care

604 Crystal Falls Pkwy, Leander, Texas 78641
Phone 512-260-0111 | FAX 512-260-1616

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

PATIENT NAME (First, Middle Initial, Last)	
ADDRESS	
CITY/STATE/ZIP	*DATE OF BIRTH*

I hereby request that Leander Dental Care provide access to, or a copy of, my:

☐ X-rays ☐ Billing records ☐ Records limited to a specific procedure or provider: _____

☐ Complete patient record* ☐ Other (please specify): _____

**Note: a fee of $6.50 may apply to all Complete Patient Record requests*

Date/Time Period

Specify Date of Service applicable to the information above: _____

Release Above Information to:

NAME of INTENDED RECIPIENT (First, Last)	
COMPANY	*PHONE*
EMAIL	*REASON FOR REQUEST (opt.)*

Format: ☐ Email ☐ Pick up in person (Date to be picked up: _____)

➢ IMPORTANT! Continue to Page 2

Processing/Denial of Request

I understand that Leander Dental Care may deny this request only in limited circumstances as provided for under federal and state law. I further understand that, except as otherwise permitted under applicable law, I have the right to have a denial of my request reviewed by a health care practitioner who did not participate in the original denial as selected by the Practice.

I understand that Leander Dental Care will notify me, in writing, of its decision to deny my request, or if the requested information is no longer available, within five (5) working days of receiving this request. Otherwise, Leander Dental Care will provide me with the requested information within a maximum of thirty (30) days unless Leander Dental Care notifies me, in writing, that a maximum of one extension of thirty (30) days is necessary due to specified factors or circumstances.

SIGNATURE OF PATIENT	*TODAY'S DATE*
SIGNATURE OF LEGAL REPRESENTATIVE (must state relationship to patient)	*TODAY'S DATE*

For Office Use Only:

☐ Picked up Date: _____

☐ Mailed Date: _____

☐ Delivered Electronically Date: _____