Record Request Protocol/Record Release Form

Updated Apr 21st 2022 by Dr. Maria-Constanza Torres

Per Health Information Privacy and Portability Act (HIPPA) and Massachusetts general law (M. G. L. c. 112 § 12CC, patients have a right to a copy of their dental records including radiographs on request within a reasonable amount of time not to exceed 30 calendar days from the date of the request with payment of the copy fee. The patient is not required to pay their account balance prior to receiving a copy of their record.

Patients can obtain their dental records by completing the records request form or by having their dentist's office submit a request on their behalf.

Please note:

- The front desk staff cannot email or fax records.
- Same day record and x-ray copying is not available. We require a turn-around time of 3-5 business days.

Patient Submitting a Request

- Patients must complete and sign the records request form
- The completed release form can be faxed, emailed, mailed, or hand-delivered
- Fax: 617-636-6858
- Email: dental.records@tufts.edu
- Mail:
  TUSDM Compliance Office
  1 Kneeland Street
  Boston, MA 02111
  Attention: Records Department

A processing fee will be charged for records to be sent directly to the patient: **$6 by email**, **$10 by mail**

A request for records to be emailed and mailed directly to the patient that includes a **CD and/or diagnostic-quality X-ray paper costs $16**

A request for records to be sent to a dentist's office is free of charge

To make a payment, please call our business office at 617-636-6986

Please allow up to 30 days for requests to be completed

To access the form, please click the link below:
https://tufts.app.box.com/v/tusdm-health-release-req-form

Provider Submitting a Request

- An email or fax request for patient records must be sent on the provider's letterhead

- Fax: 617-636-6858, or Email: dental.records@tufts.edu
- A request for records to be sent to a dentist's office is free of charge
- Please allow up to 30 days for requests to be completed

Fees

- Fees are applied if the patient would like their records to be sent to them directly
- A request for records to be sent to a dentist's office is free of charge
- Fees must be paid in full before records can be released
- Payments can be made over the phone with our business office at 617-636-6986

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Authorizing Release of My Health Information by TUSDM

PATIENT INFORMATION:

NAME:	DATE OF BIRTH:	PHONE:	
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:

INFORMATION TO RELEASE, FORMAT & DELIVERY:

STANDARD INFORMATION TO RELEASE (Choose all that apply):	SENSITIVE INFORMATION TO RELEASE (Choose all that apply and sign below):
☐ X-Rays ☐ CBCT* ☐ Case Notes/Treatment History ☐ Billing/Financial Statements ☐ Complete Record Set ☐ Other (please explain): **CBCT Requests may only be provided on a CD.*	☐ HIV/AIDS test/treatment ☐ Sexually transmitted disease ☐ Drug/alcohol problem ☐ Mental health information ☐ Genetic testing ☐ Sexual Assault ☐ Abortion By law, you are required to sign below to have us release sensitive information that may be in your record. X _____
FORMAT TYPE (Choose one): ☐ Email Attachment ($6) ☐ X-Ray Diagnostic Quality Paper ($10) ☐ CD ($10) ☐ Review in Person (No fee) ☐ Dentist to Dentist (No fee)	
DELIVERY METHOD (Choose one): ☐ Mail to patient address provided above. ☐ Mail to different address. Provide address → ☐ Dentist to Dentist. Provide phone number → ☐ Email. Provide email address → ☐ Fax. Provide fax number → ☐ Pick up in person.	DELIVERY INFORMATION (E-mail, Fax, or Mailing Address if different from above): _____ _____ _____

AUTHORIZATION:

I understand there may be a fee for this service. I will have the opportunity to change my request before being charged, if I so choose. Please see our website at *dental.tufts.edu* or contact our clinic front desk staff for additional information.

SIGNATURE OF PATIENT OR PATIENT'S AUTHORIZED LEGAL REPRESENTATIVE: X	DATE:	FUTURE STATUS: ☐ Continuing at TUSDM ☐ Going to Different Provider
AUTHORIZED LEGAL REPRESENTATIVE INFORMATION (If applicable): Printed name:	Relationship to patient:	

SEND FORM AND MAKE PAYMENT:

1) SEND COMPLETED FORM →	**STANDARD MAIL:** TUSDM Compliance Office 1 Kneeland St., Suite 1531 Boston, MA 02111	**EMAIL:** dental.records@tufts.edu	**FAX:** (617) 636-6858
2) MAKE PAYMENT → NOTE: Requests that include CDs or Diagnostic Quality Paper are $10 total. All other requests are $6 total.	**CHECK OR MONEY ORDER:** Mail to address above. Make payable to "TUSDM" (Include check/money order with form.)	**CREDIT CARD:** Call (617) 636-6986	