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Authorization to Duplicate, Use, or Disclose Protected Health Information

Patient/Member, Parent, or Personal Representative Request
Other Requestor

PATIENT INFORMATION:

SEND TO:

Name:	Dr. Mr. Mrs. Ms. (circle one)
Address:	Name:
City:	Address:
State: Zip:	City:
Email:	State: Zip:
Phone: ()	Email:
Fax: ()	Phone: ()
	Fax: ()

Description of Information Requested: *(describe records or information to be released)*

Payment for records duplication is due at the time of request. Duplication of records will be processed within 2 days of receipt of payment.

Dental Chart - \$10 X-Rays - \$10

I authorize Menlo Park Dental Excellence to duplicate, use, or disclose my protected health information as described above. The member/patient, parent, or personal representative must sign this Authorization.

Signature: _____ Date: _____

Description of representative's authority (parent/guardian, etc.) _____