STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
DENTAL HYGIENE COMMITTEE OF CALIFORNIA
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P (916) 263-1978 | F (916) 263-2688 | www.dhcc.ca.gov

AUTHORIZATION FOR RELEASE OF DENTAL/MEDICAL PATIENT RECORDS

Patient Name: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, authorize any physician, dentist, medical practitioner, hospital, clinic or other dental or dental related facility having records (original and/or electronic) available as to diagnosis, treatment and prognosis with respect to any dental or medical condition and/or treatment of me (or the patient) to release to the Dental Hygiene Committee of California (DHCC) or any DHCC representative, related local, state and federal governmental agencies, including but not limited to, investigators and legal staff.

I understand that this information will be maintained in confidence and will be used solely in conjunction with any investigation and possible legal proceeding regarding any violations of California laws and regulations. I further agree to allow the DHCC representatives and related governmental agencies, to process and possibly file other charges based on my complaint.

I also understand that the subject of my complaint may receive a copy of my complaint and records pursuant to the Administrative Procedures Act and the Information Practices Act.

I agree that a photocopy of this Authorization shall be as valid as the original. This Authorization shall remain valid until the DHCC or other authorized government agency completes its review and the proceedings arising out of the investigation.

I understand that I have a right to receive a copy of this authorization if requested by me.

Patient/Guardian

SIGNATURE:_____ **DATE:**_____

NOTE: Must attach written proof of authorization to act on patient's behalf.

NOTE TO THE PROVIDER:
This release is compliant with the requirements of HIPPA and Civil Code Section 56.11.