RABEH H. EBEED, B.D.S., D.D.S., F.A.G.D.
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The Federal Health Insurance Portability and Accountability (HIPAA) requires that Dr Ebeed and all of the attending doctors in his practice adhere to specific rules when using and discussing protected health information regarding patients. If you would like a copy of your dental record, the completion of this form is required.

I, _____ on this date _____ authorize the release of a copy of my dental record in one of the following ways listed below. I also acknowledge that copying fees may apply in this transaction as listed in your Notice of Privacy Practices.

□ Please send a copy of the following records (including information from other health care providers) to 26 Derry Street, Hudson NH 03051:

Name _____ **DOB** _____

_____

_____

_____

□ Please e-mail my records and current x-rays to: newlookdental@hotmail.com

□ Please allow a copy of my record be picked up by:

_____

_____
Patient signature

_____
Witness Signature