UNIVERSITY OF WASHINGTON
SCHOOL OF DENTISTRY
ORAL AND MAXILLOFACIAL PATHOLOGY SERVICE

~ AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION AND RECORD ~

In order to comply with Washington state laws regarding confidentiality, the School of Dentistry, Oral and Maxillofacial Pathology Service (OMPS) must have your written permission to release information. Under the Health Insurance Portability & Accountability Act (HIPAA), all healthcare facilities are required to have several area of the form completed in full. If any of the required elements (noted by "") are not completed in full, this authorization request becomes invalid, and must be returned to you for proper completion.*

1. Patient Information *

Patient Name:	
Patient Account #:	
Birth Date:	
Patient Address:	
Telephone #:	

2. Health Information to be Disclosed *

- ☐ Laboratory and/or Consultation Reports
- ☐ Billing and Insurance Information
- ☐ Other: _____

3. Health Information Period for Disclosure *

- ☐ Prior 2 years
- ☐ Prior 5 years
- ☐ Other: _____

4. My Revocation Rights

I understand that I have a right to revoke this authorization in writing at any time except:

- When the OMPS has already taken action based on this authorization or
- Where authorization was required for my insurance coverage.

5. Authorization Expiration

Unless revoked by me, I understand that this authorization will expire in ninety (90) days from the date of my signature below or from _____ (no more than 90 days from the date signed) except under the following situation:

- Authorizations given to provide information to a third-party payer or
- Agreement with a disciplinary authority.

6. My Rights

I understand that I do not have to sign this authorization in order to receive health care treatment or obtain health care payment benefits except for the following situation:

- I am taking part in a research-related treatment program or study where OMPS requires such or
- I am receiving health care from OMPS soley for the purpose of creating health care information for a third party.

I further understand that once my health information has been disclosed by the OMPS, the recipient may re-disclose my health information, and it will no longer be protected under the health privacy laws. I release the University of Washington, School of Dentistry staff and counsel from all responsibility or liability that may arise from authorized release of information.

7. Health Information / Record Recipient *

I hereby authorize the Oral and Maxillofacial Pathology Service at the University of Washington to discuss and release all related patient's health information to the recipient(s) listed below, for the following purpose(s):

☐ Healthcare ☐ Legal ☐ Insurance/Billing ☐ Other (describe): _____

Recipient's Name / Organization:	
Recipient's Mailing Address:	
Recipient's Telephone #:	

Patient or legally authorized individual signature *

Date & Time *

Printed Name *

Relationship (if requester is other than patient) *

Patient Account Number *

Social Security Number

RESET FORM