Clear Form Print Form

Patient Authorization for UW School of Dentistry to Disclose/Release Protected Health Information

Patient Name: _____ Date of Birth: _____

Purpose of Disclosure: _____

or ☐ The disclosure is made at the request of the individual.

INFORMATION TO BE RELEASED FROM:	**INFORMATION TO BE RELEASED TO:**
☐ UW School of Dentistry	☐ UW School of Dentistry
OR	**OR**
Name of Organization/Person	Name of Organization/Person
Phone# Fax #	Phone# Fax #
Street Address	Street Address
City State Zip Code	City State Zip Code

Type of Information *(check appropriate box):*

☐ **All Radiographs/X-rays/CBCT from date:** _____ **to date:** _____

☐ **All Chart Entries from date:** _____ **to date:** _____
(Chart notes, Health History, Periodontal Charting & Treatment Plan)

☐ **Other** (please specify):_____

Copy Fees:

Radiographs/X-rays/CBCT - $19/CD

Chart entries - $0.26 per page
(No charge for chart notes if less than 5 pages)

OR:

☐ **I authorize VERBAL COMMUNICATION ONLY about my dental history and care**. *(Checking this box means no physical records will be sent)*

Patient Authorization: I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric condition. I give my specific authorization for this information to be released: Yes☐ No☐

This authorization is valid until _____ (date) OR when the following event occurs: _____
(State when UW School of Dentistry is no longer authorized to disclose my information based on this authorization. If no date or event is listed above, this authorization is valid for 90 days from the date on which it is signed.)

Note: Authorization to disclose your information to an employer or financial institution can only be effective for maximum of 90 days from the date signed by you.

By signing this page, I acknowledge that I have read and agreed to the terms on both sides of this form.

Signature (Patient or Person Authorized to give authorization)	Date
If signed by person other than patient, please print your name, provide reason, relationship to patient & description of authority	

Patient Information: Chart # _____

Last Name First Name M.I.

Date of Birth Phone #

Street Address

City State Zip Code

This authorization form can be returned by mail or fax to:

UW School of Dentistry
Dental Records Department
Box 357131
Seattle, WA 98195
Phone: 206-543-7049
Fax: 206-221-4434

Mail check along with the release form or call the number above to pay by phone with a Visa, MasterCard or Discover Card. Please make checks payable to University of Washington, School of Dentistry. If patient is under 18 and is covered by Apple Health insurance, please include Provider One ID number: _____

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Minors: A minor patient's signature is required in order to release the following information (1) conditions relating to the minor's reproductive care (2) sexually transmitted diseases (if age 14 and older), (3) alcohol and/or drug abuse and mental health conditions (if age 13 and older)

Patient Rights: I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization at any time except to the extent already relied upon, by sending a request in writing to UW School of Dentistry Records Custodian Box 357131, Seattle, WA 98195. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

I understand that I have the right to:

- Inspect or to receive a copy of the protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information

I also understand that UW School of Dentistry will not base treatment or payment decisions based on receipt of this signed authorization, except in these cases: (1) UW School of Dentistry may condition research-related treatment on my signing or my providing an authorization for the use or disclosure of my information for such research; **or** (2) UW School of Dentistry may condition the provision of health care that is just for the purpose of creating health information for disclosure to a third party on my signing or my providing an authorization for the disclosure of the health information to such third party. An example of this is when a non-UW employer contracts with UW School of Dentistry to conduct TB testing for purposes of employee health screening.