Appendix A

SCHOOL OF DENTISTRY
UNIVERSITY of WASHINGTON

Western Regional Examination Board ("WREB") PHI Consent Form

Patient Authorization to Disclose, Release or Obtain Protected Health Information

I, _____, authorize UW School of Dentistry to disclose protected health information about me to dental students for the purpose of assisting them in the dental licensing exam process. I understand that the dental licensing exam process is directed by the Western Regional Exam Board (WREB), a national dental testing agency that is independent of the School of Dentistry.

UW School of Dentistry may disclose protected health information; including, but not limited to, my name, birth date, dates of treatment, treatment records that include medical and dental history, x-rays/imaging and dental and full facial photographs.

This authorization is valid for one year from the date on which it is signed unless I revoke this Authorization sooner.

I understand I do not have to sign this authorization in order to continue to receive care at the School of Dentistry. 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 Compliance Office Box 356365 Seattle, WA 98195.

Signature (Patient or person authorized to give authorization): _____

Date: _____

If signed by person other than patient, provide reason, relationship to patient and description of their authority: _____

form: HIPAA-007
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