MIDWESTERN UNIVERSITY DENTAL INSTITUTE

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RELEASE OF INFORMATION FORM

Instructions

Please complete this form in full and return it to us by U.S. Mail, fax, or email. While we try to expedite the release of your records, we are allowed up to 14 business days to complete the request.

I, the undersigned, hereby authorize Midwestern University to use and/or disclose the protected health information about me described below to the following individual or entity. Please provide a complete name and mailing address. If requesting a copy of your records for your own use, provide your name and mailing address. We can send records electronically, but the receiving individual should be aware that the records will be sent through a secure website, not as an email attachment. This is required by law to protect the security and privacy of your health records.

Release Records to Whom: _____

Address: _____

E-mail address (if above can accept electronic records): _____

___ I acknowledge that I understand the purpose of the request and that authorization is hereby granted knowingly and voluntarily.

Patient Information

Patient Name: _____ **Patient Date of Birth:**_____

Patient Address: _____ **Patient Phone Number:**_____

Information to be Disclosed

Please check the box(es) of the sections of your dental records that you wish disclosed. If you need specific information, check the box and provide details in the "Other Information or Documents" area.

___ **Dental Chart Records - Including:**

- ***Alcohol and Drug Abuse Treatment.** To the extent that my medical record contains information regarding alcohol or drug treatment that is protected by federal law, I authorize the disclosure of such information or record.
- ***HIV/AIDS Information.** To the extent that my medical record contains information regarding my HIV/AIDS status, treatment, or testing, I authorize disclosure of such information.
- ***Behavioral Health Notes/Records.** I authorize the disclosure of any behavioral health notes or information in my medical record.

___ **Radiographic Images (X-rays)**

___ **Photographs**

___ **Other information or documents (if any):** _____

___ **Do Not Disclose** (If you do not want a certain portion of your chart disclosed, please provide that information here): _____

Purpose

Please provide the reason you are requesting your records.

___ Treatment ___ Financial ___Personal

___ Insurance ___Do Not Disclose Purpose

___ Other (Specify): _____

Release Authorization

This authorization shall expire 1 year from date of signature unless otherwise specified here:

_____

I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Director of Clinical Systems, Midwestern University Dental Institute, 5855 W. Utopia Rd., Glendale, AZ 85308. I understand any revocation is not effective to the extent action has already been taken in reliance on this authorization. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal or state law. This authorization is not intended to affect a patient's ability to receive medical / dental care and I understand that I have the right to refuse to sign this authorization.

By my signature below, I consent to the release of the above listed information/documents.

Patient Signature: _____ Date: _____

Parent/Guardian/Legal Power of Attorney

I certify that I am a parent or guardian of Patient, or that I hold legal power of attorney for the parent of Patient. In this capacity, I represent and warrant, by signing above, that I have legal authority to execute this Agreement on behalf of Patient. If the patient (or parent if minor) is not signing, we must have on file guardian or Health Care Power of Attorney documents in order for us to release the records.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____

Relationship to Patient: _____

Address: _____ Phone: _____