MIDWESTERN UNIVERSITY DENTAL INSTITUTE

5855 W Utopia Road, Glendale, AZ 85308-5251 **tel:** 623-806-7000 **fax:** 623-806-7010 **email:** azmwudentalclinic@midwestern.edu

RELEASE OF INFORMATION FORM

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.

(1) 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

(2) Patient's Name: Patient's Date of Birth:

Patient's Address: Patient's Phone Number:

☐ **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, treatement, 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.

(3)

☐ **Radiographic Images (Xrays)**

☐ **Photographs**

☐ **Other Information or Documents (if any):** _____

(4) ☐ **Do Not Disclose:** _____

Purpose:

(5) ☐ Treatment ☐ Financial ☐ Personal ☐ Insurance ☐ Do Not Disclose Purpose

☐ Other (Specify):

(6) **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		
(7) ⇨ **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.		
Parent/Guardian Name:		
(7) ⇨ **Parent/Guardian Signature:**		**Date:**
Relationship to Patient:		
Contact Information:	**Address:**	**Phone**

Midwestern University Dental Institute

Instructions - Completion of Release of Information

Please complete each section of the release in full. This guide will explain what information is being requested.

(Section 1) This is the individual or health care provider to whom we will be sending your records. If requesting your records to your self, provide your name & mailing address. We need their complete name & mailing address. We can send records electronically, but the receiving individual should be aware that the records will be sent through a secured website, not as an email attachment. This is required by law to protect the security and privacy of your health records.

(Section 2) Please provide the patient's full name, address, phone number and date of birth.

(Section 3) 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.

(Section 4) If you do not want a certain portion of your chart disclosed, please provide that information here.

(Section 5) Please provide the reason you are requesting your records.

(Section 6) The release is effective for 1 year, unless you provide an earlier or later termination date.

(Section 7) Print the name of the patient OR Parent / Guardian / Health Care Power of Attorney that is signing the release. 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.

(Section 8) Signature and date document is signed.

The release can be returned to us by US Mail, FAX or email. Information is provided on the top of the release form.

While we try to expedite the release of your records, we are allowed up to 14 business days to complete the request.