UIC UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF DENTISTRY

Office for Registration and Records 801 S. Paulina, Room 105 Chicago, IL 60612 (312) 355-1984

# AUTHORIZATION TO RELEASE HEALTH INFORMATION

*** There will be a fee for copies ****

**Patient Name**: _____ **Chart Number** (if known): _____
(Last / First/ Middle)

**Patient Date of Birth**: _____/_____/_____ **Telephone**: (_____)_____

**I hereby authorize the Custodian of Dental Records at the University of Illinois at Chicago-College of Dentistry, to release my dental health records to:**

Person / Facility or Agency: _____

Address: _____

City: _____State_____ Zip_____

☐ Please send my records sent electronically to email address _____

**Specific description of information that may be used/disclosed (check all that apply):**

☐ Dental radiographs ☐ Electronic treatment notes ☐ Other *(please specify)*_____

**Dates of Treatment:** from _____/_____/_____ to _____/_____/_____

**The information will be used/disclosed for the following purpose:**

☐ Continuing Care ☐ Personal ☐ Legal ☐ Other (*please specify*)_____

**I authorize the University of Illinois to release sensitive information as indicated:**

The patient 12 or over who consented to the treatment must authorize the release of sensitive information.

☐ AIDS/HIV ☐ Drug/Alcohol Abuse ☐ Behavioral Health
☐ Sexual Assault ☐ Child Abuse ☐ Developmental Disabilities

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

**I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. I understand that, if the persons or organizations I authorized above to receive and/or use the protected health information described above are subject to federal health information privacy laws, they may further disclose the protected health information and this information may no longer be protected by federal privacy laws and regulations.**

_____ _____
Patient Signature DATE

_____ _____
Legal Representative Signature Relationship to Patient

_____ _____
Witness Signature Relationship to Patient

If not otherwise specified, this authorization will expire within 90 days of the date of signature

**Return this form to the Office for Registration and Records in Room 105 or via fax (312) 413-0947**