Authorization to Release Patient Information

SCHOOL OF DENTISTRY
UNIVERSITY OF MICHIGAN

Please Return to:
Central Records, Rm B390
University of Michigan School of Dentistry
1011 N. University Ave.
Ann Arbor, MI. 48109-1078
Phone: 734-764-6152 Fax: 734-615-7040
Questions? email: dentalrecordcopy@umich.edu

I AUTHORIZE THE UNIVERSITY OF MICHIGAN SCHOOL OF DENTISTRY, ITS AGENTS AND ITS EMPLOYEES TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME / MY CHILD TO THE RECIPIENT WHICH MAY INCLUDE ALCOHOL AND DRUG ABUSE TREATMENT; PSYCHOLOGICAL AND SOCIAL WORK COUNSELING; HIV OR AIDS OR ARC; COMMUNICABLE DISEASE OR INFECTIONS, INCLUDING SEXUALLY TRANSMITTED DISEASES, VENEREAL DISEASE, TUBERCULOSIS AND HEPATITIS; AND DEMOGRAPHIC INFORMATION; FOR THE PURPOSES, AND UNDER THE CONDITIONS DESIGNATED ON THIS FORM.

PATIENT INFORMATION

First Name	Last Name		Date of Birth
Street Address	City, State	Zip Code	Phone Number

SEND RECORDS TO: (Choose only ONE Delivery Option)

☐ **SEND BY MAIL TO:**

Self or Name of Dentist, Physician, Institution, Clinic, Etc.

Address

City, State, Zip Code

Phone Number

☐ **SEND BY ENCRYPTED EMAIL TO:**

Self or Name of Provider/Clinic Phone Number

E-mail address

☐ **CALL FOR PICK-UP School of Dentistry, Room B390**

Self or Name of Representative Phone Number

INFORMATION TO BE DISCLOSED: **DATES**

☐ X-Rays/ Imaging* From_____to _____

☐ Exam and Treatment Notes* From_____to _____

☐ Specific Information_____

PURPOSE(S) FOR DISCLOSING INFORMATION:

☐ Continuation of Care/Consultation
☐ Social Security/Disability Certification
☐ Workers Compensation
☐ Attorney Inquiry/Legal Matter
☐ Insurance Claim/Application

*Most recent records may include up to the last 5 years of treatment, unless otherwise specified.

EXPIRATION (may be a specific date or a condition; if left blank, expires 6 months from date below):

This authorization expires: _____

REVOCATION, REDISCLOSURE, AND CONDITIONING OF ELIGIBILITY:

REVOCATION: I understand that I may revoke my authorization by writing to the School of Dentistry, Attention: Central Records, 1011 N. University, Ann Arbor, MI 48109-1078. After it is revoked, UM School of Dentistry will make no further disclosures to the above persons without a new authorization. UM can rely on this authorization until it is revoked or until the expiration date or conditions are met. A request to revoke my authorization will not apply to the extent UM has taken action in reliance upon my authorization. In the event that the authorization was obtained as a condition of providing insurance coverage, the revocation will not apply to my insurance company to the extent that the law provides my insurer with the right to contest a claim under the policy, or the policy itself.
REDISCLOSURE: Once information has been disclosed, it may no longer be protected from further disclosures by federal or state privacy laws.
CONDITIONING OF ELIGIBILITY: UM will not condition treatment, payment, enrollment, or benefit eligibility on my signing this document.
TIME FRAME: Please allow a period of two business days to process and complete your request.

SIGNATURE:_____ DATE: _____

AUTHORIZATIONS SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR A POWER OF ATTORNEY.