AUTHORIZATION TO RELEASE PATIENT INFORMATION

UNC SCHOOL OF DENTISTRY
PATIENT RECORDS
TARRSON HALL CB#7450
CHAPEL HILL, NC 27599-7450

PHONE: (919) 537-3515 FAX: (919) 537-3625

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

REQUIRED FEE: I AGREE TO PAY THE $6.00 REPRODUCTION OF RECORDS FEE, WHICH FEDERAL AND STATE LAW ALLOW THE UNC SCHOOL OF DENTISTRY TO CHARGE. I AM PAYING BY CASH OR CHECK (ENCLOSED) OR WILL CALL THE CONTACT NUMBER ABOVE WITH MY CREDIT CARD INFORMATION.

PATIENT INFORMATION

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

DELIVERY OPTION (Choose only one)

☐ **SEND BY MAIL TO:**

Recipient *(Self or Name of Provider/Other Entity)*

Address

City, State, Zip Code

Phone Number

☐ **SEND BY ENCRYPTED EMAIL TO:**

Recipient Phone Number

E-mail Address

☐ **CALL FOR PICK-UP**

Tarrson Hall, Room B0022

Self or Name of Representative Phone Number

INFORMATION TO BE DISCLOSED:

	DATES
☐ X-Rays/Imaging	From _____ to _____
☐ Exam and Treatment Notes	From _____ to _____

Other Information: _____

PURPOSE(S) FOR DISCLOSING INFORMATION:

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

REVOCATION AND REDISCLOSURE: I understand that I may revoke my authorization in writing to the UNC School of Dentistry Patient Records Office. The UNC School of Dentistry can rely on this authorization until it is revoked or until conditions are met. I understand that once my information has been disclosed, it may no longer be protected from subsequent disclosures by federal or state privacy laws.

CONDITIONING OF ELIBIGLITY: Your treatment eligibility will not be affected by signing or refusing to sign this document.

TIME FRAME: Please allow a period of 10 business days to process and complete your request.

SIGNATURE:_____ **DATE:**_____

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