University of Maryland, School of Dentistry

Authorization for the Use and Disclosure of Protected Health Information

University of Maryland, School of Dentistry
650 West Baltimore
Baltimore, Maryland 21201

Date_____ **Patient Name**_____

Patient Record Number_____ **Patient SSN**_____

As required by the Health Insurance Portability and Accountability Act of 1996 University of Maryland, School of Dentistry may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to the School of Dentistry.

AUTHORIZATION SECTION

I, _____hereby authorize the use and disclosure of the following health
(print name)
information that pertains to me or my child _____
(print name)
OR another person I am authorized to represent _____
(print patient's name)
as _____.
(give relationship or legal authority)

This authorization allows the release of the following information:

☐ Dental History	☐ Consultation and Laboratory Reports
☐ Medical History	☐ Contact Information
☐ Radiographs	☐ Photographs and Other Images
☐ Interviews	☐ _____ (other)
☐ Dental Models	
☐ Progress Notes and Treatment Plans	

For the following purpose(s):

☐ Research	☐ Promotional
☐ Education	☐ Legal Procedures
☐ Continued Health Care	☐ _____ (other)
☐ Continuing Education Seminars outside the School	

I authorize the following persons to make or receive these disclosures of my health information:

Name _____

Address _____

UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

University of Maryland, School of Dentistry

- I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected.
- I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to University of Maryland, School of Dentistry, Associate Dean of Clinical Affairs, 650 West Baltimore Street, Room 5209 Baltimore, Maryland, 21201.
- I further understand that any such revocation does not apply to the extent that person authorized to use to disclose my health information have already acted in reliance on this authorization.
- I understand that this authorization will automatically expire in one year or on the date I have authorized. _____
- I further understand that my ability to obtain treatment will not depend in any way on my agreement to this authorization.
- I understand the School of Dentistry will charge me $_____ for duplication of this information.

_____ _____

Signature Date

Processing your request for copies of records and radiographs takes approximately ten working days after receipt of the authorization form and payment. Please make check payable to University of Maryland and send to the attention of Dental Records Supervisor. To reach us by telephone, call 410-706-3437.

REVOCATION SECTION

I hereby revoke this authorization.

_____ _____

Signature Date