

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 describe d 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:

<input type="checkbox"/> Dental History	<input type="checkbox"/> Consultation and Laboratory Reports
<input type="checkbox"/> Medical History	<input type="checkbox"/> Contact Information
<input type="checkbox"/> Radiographs	<input type="checkbox"/> Photographs and Other Images
<input type="checkbox"/> Interviews	<input type="checkbox"/> _____ (other)
<input type="checkbox"/> Dental Models	
<input type="checkbox"/> Progress Notes and Treatment Plans	

For the following purpose(s):

<input type="checkbox"/> Research	<input type="checkbox"/> Promotional
<input type="checkbox"/> Education	<input type="checkbox"/> Legal Procedures
<input type="checkbox"/> Continued Health Care	<input type="checkbox"/> _____ (other)
<input type="checkbox"/> 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

- 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