# Authorization to Release Patient Information

SCHOOL OF DENTISTRY
UNIVERSITY OF MICHIGAN

**Central Records**
**University of Michigan School of Dentistry**
**1011 N. University Ave.**
**Ann Arbor, MI. 48109-1078**
**Phone: 734-764-6152 Fax: 734-615-7040**
**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 |
| Email: | | | |

**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

**INFORMATION TO BE DISCLOSED:**

☐ Recent xrays/ treatment notes
(May take two business days to complete)

☐ Specific Information_____
(Archived records may take two weeks to complete)

**PURPOSE(S) FOR DISCLOSING INFORMATION:**

☐ Consultation
☐ Attorney Inquiry/Legal Matter
☐ Insurance Claim
☐ **Other:** _____

**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.

**SIGNATURE:**_____ **DATE:** _____

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