



School of Dentistry  
 Patient Services  
 Central Records Rm. B390  
 1011 N. University Street  
 Ann Arbor, Michigan 48109-1078  
 Phone: 734-764-6152  
 Fax: 734-615-7040

**UNIVERSITY OF MICHIGAN  
 SCHOOL OF DENTISTRY  
 AUTHORIZATION TO RELEASE  
 PATIENT INFORMATION**

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.

<b>PATIENT:</b>		<b>RECIPIENT:</b>	
_____ Patient's Name	_____ Registration Number (not SSN)	_____ Self or Name of Physician, Institution, Clinic, Etc.	
_____ Patient's Address		_____ Address	
_____ City, State, Zip Code		_____ City, State, Zip Code	
_____ Patient's Date of Birth	_____ Phone Number	_____ Phone Number	_____ FAX Number

<b>INFORMATION TO BE DISCLOSED:</b>	<b>PURPOSE (S) FOR WHICH THE INFORMATION MAY BE DISCLOSED:</b>
<input type="checkbox"/> Psychotherapy Notes From _____ to _____ <i>NOTE: Disclosure of Psychotherapy Notes requires a separate authorization form.</i> <input type="checkbox"/> Outpatient Reports From _____ to _____ <input type="checkbox"/> Inpatient Reports From _____ to _____ <input type="checkbox"/> Radiology Reports From _____ to _____ <input type="checkbox"/> Laboratory Tests From _____ to _____ <input type="checkbox"/> Specific Records From Specific Dates (Give Dates) _____ <input type="checkbox"/> All of the above information <input type="checkbox"/> Billing information From _____ to _____ <input type="checkbox"/> See Other Side for Duplication of Records	<input type="checkbox"/> At the Request of the Patient <input type="checkbox"/> Continuation of Care/Consultation <input type="checkbox"/> Social Security/Disability Certification <input type="checkbox"/> Insurance Claim/Application <input type="checkbox"/> Attorney Inquiry/Legal Matter <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Other: (specify) _____ <input type="checkbox"/> VIEW ONLY ON CAREWEB (NO COPIES WILL BE SENT)

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

This authorization expires \_\_\_\_\_

**REVOCAION, REDISCLOSURE, AND CONDITIONING OF ELIGIBILITY:**

**REVOCAION:** I understand that I may revoke my authorization by writing to School of Dentistry; 1011 N. University, Ann Arbor, MI 48109-1078; (734) 763-6933. 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:** \_\_\_\_\_  
 (Patient, Parent, Legal Representative)

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

**UNIVERSITY OF MICHIGAN  
SCHOOL OF DENTISTRY  
CENTRAL RECORDS DEPARTMENT**

**Patient Release for Record Duplication**

**Requests for record and x-rays may take 10 working days.**

The average cost for duplication is \$10.00 for full-mouth x-rays and \$10.00 for the record. If your record is housed at the University's off-site storage facility, duplication may take up to 30 working days.

PLEASE NOTE: To return by mail; please include this completed form and check to:  
Central Records, UM School of Dentistry, 1011 N. University, Room B390, Ann Arbor, MI 48109-1078.  
If you need assistance, please call the duplication line (734-764-6152).

**Duplication Request**

**1** Please check the appropriate box. I am requesting duplication of my:

- Dental Record (paperwork only) \$10.00
- Full-mouth X-rays (includes Panorex) \$10.00
- Panorex (only) \$5.00

If making payment by (circle one) Visa, Mastercard or Discover:

Card Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Total Cost \$ \_\_\_\_\_

Make check out for this amount to the University of Michigan

**Patient Mailing Instructions**

**2** Please mail my requested duplication to:

- Pick-up - Call when ready
- My address given above.
- A different address. If this box is checked, please print the complete information below.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**Patient, please DO NOT mark below this line. Thank You.**

Info Taken By \_\_\_\_\_ Date \_\_\_\_\_

Chart # \_\_\_\_\_

Subpoena Number \_\_\_\_\_ Check No. \_\_\_\_\_

Authorized By \_\_\_\_\_ Date \_\_\_\_\_

X-rays Duplicated By \_\_\_\_\_ Date \_\_\_\_\_

Entered In Log By \_\_\_\_\_ Date \_\_\_\_\_

Record Duplicated By \_\_\_\_\_ Date \_\_\_\_\_