Penn Dental Medicine

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMTION

Patient Name (First, Middle, Last)	Date of Birth
Address	City/State/Zip Code
Email Address	Phone Number

Disclosed Information: (check all items to be released)

☐Entire Record ☐Billing Statements (with procedure codes) ☐Medication Record ☐Lab Reports
☐X-Rays ☐History and Physical
☐Other: (please specify) _____

Special Records: I understand that information related to my diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, treatment for drug and alcohol abuse may be released as part of my health information. Please check the appropriate box(es) below.

AIDS/HIV Information	Psychiatric Care/Treatment	Treatment for Drug or Alcohol use/abuse
___Yes, disclose	___Yes, disclose	___Yes, disclose
___No, do not disclose	___No, do not disclose	___No, do not disclose

Information to be Provided To:	Telephone Number
Name of Person or Institution_____	
Address_____	Fax Number _____
City/State/Zip Code_____	Email_____
Format (Check One): ☐Paper Copy ☐CD (Compact Disc) ☐Encrypted Email	

Authorization

I hereby authorize Penn Dental, its agents and its employees to release protected health information described above.

I understand that my authorization will automatically expire one hundred eighty (180) days after the date of signature on this form.

I understand that I may revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing to Records Department, Penn Dental, Room LL102, 240 S 40th Street, Philadelphia, PA 19104-6030. I understand the revocation will not apply to information that has already been released in response to this authorization.

My refusal to sign this authorization will not affect my ability to receive treatment. By signing this form, I understand that I am authorizing Penn Dental to release information as described above. In the event this 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 itself.

Once information has been disclosed, it may not be protected from further disclosures by federal or state privacy laws.

Signature of Patient or Personal Representative Print Name Date

Relationship of Personal Representative to Patient

Authorizations signed by a legal representative must include a copy of the guardianship papers or a Power of Attorney

PLEASE READ INSTRUCTIONS ON REVERSE
Instructions for Completing the Authorization for Disclosure of Health Information

1. Please complete all sections of the Authorization for Disclosure of Health Information

2. The patient or legally authorized representative must sign and date the form.

Generally, only a patient may authorize release of his/her medical information.
Exceptions to the rule are as follows:

a. Authorization of Minors-if the patient is a minor (under 18 years of age), the authorization must be signed by a parent or legal guardian

b. Emancipated minors-An emancipated minor is a minor under the age of 18, who is or has been married or has been pregnant or who is a high school graduate. Emancipated minors can authorize release of their medical information.

c. A minor who has been diagnosed with a venereal disease, a substance abuse problem or was treated to determine pregnancy may consent to treatment of that disease or condition and may authorize release of medical information related to that disease or condition.

d. Authorization after death-An authorization must be signed by decedent's estate, or in the absence of an executor, the next of kin responsible for the disposition of the remains may give consent for the release of medical information.

e. Authorization of incompetent patient-If the patient is deemed incompetent, then the patient's legally authorized representative must sign the authorization for release of information.

Penn Dental reserves the right to request proof of representation.

The address for Penn Dental Records Department:

Records Department, Room LL102, 240 S. 40th Street, Philadelphia, PA 19104-6030, Phone: (215) 573-3580, Fax: (215) 573-3069, Email: records@dental.upenn.edu

Please Note:

1. Records request cannot be filled on the same day
2. Requestor must provide Penn Dental with a copy of two (2) forms of identification (i.e. a driver's license, passport or work identification). At least one (1) must be a photo identification
3. If you have not been treated at Penn Dental in over 3 months or if your chart has been archived, your request may take 5-7 days to process
4. Penn Dental Medicine will charge for records in accordance with a schedule of fees established by applicable state law.
5. **Charges for Duplication: $6.50, Please check the items that you are requesting.**
   ☐ X-Rays
   ☐ Records
6. If the patient has Medicaid, there is no fee. Please provide a copy the front and back of your insurance card.
7. X-rays and Records will be copied on a disc unless printed copies are specifically requested.
   Payment Options:
   a. **Cash**: In person only.
   b. **Credit Card**: ☐Visa ☐MasterCard ☐Discover
      All credit card payments must be made in person or by phone. Please call our billing office at 215-746-4675 to pay by phone.
   c. **Check:** Made payable to Penn Dental Medicine

PLEASE DO NOT WRITE BELOW THIS LINE

Record #_____ Processed By: _____

Date:_____