Penn Dental Medicine
University of Pennsylvania

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

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

Records to be Disclosed: (check all items to be released)

☐ Entire Record

OR

☐ Treatment Notes ☐ Billing Statement (with procedure codes) ☐ Electronic Health Record Forms ☐ Consent Forms
☐ X-Rays ☐ Transactions & Balance Summary ☐ Treatment Plans ☐ Prescriptions
☐ Contact Notes ☐ All Attachments
☐ 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:

Name of Person or Institution_____

Address_____

City/State/Zip Code_____

Purpose of requested Information: ☐ Legal ☐ Insurance ☐ Personal ☐ Continuation of Care
☐ Other_____

Delivery Method: ☐ Paper Copy (2-3 weeks) ☐ CD (2-3 weeks) ☐ Email (Not Secure)

Telephone Number

_____

Fax Number

_____

Email

_____

Important: I understand that the CD is not encrypted and may be accessible to others if the CD is lost or stolen. I also understand that unencrypted email is not secure – and therefore may be intercepted by others. I also understand that email may be misdirected and easily forwarded to unintended recipients. By choosing to receive my health information by CD or via email, I am accepting these risks.

Authorization

I hereby authorize Penn Dental Medicine (PDM), 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 Penn Dental Medicine Records Department, 240 S 40th Street, LL102, Philadelphia, PA 19104-6030. I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by relevant federal and/or state law. If I have requested to receive health information electronically, I acknowledge and accept the risks described above concerning unencrypted electronic formats. My refusal to sign this authorization will not affect my ability to receive treatment.

Signature of Patient or Personal Representative | Print Name | Date

Relationship of Personal Representative to Patient | If Authorization is signed by someone other than the patient, state reason

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

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 bene 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.

Penn Dental Medicine Records Department:

Penn Dental Medicine Records Department
240 S. 40th Street, LL 102
Philadelphia, PA 19104-6030

Phone: (215) 573-3580; Fax: (215) 573-3069; E-Mail: records@dental.upenn.edu

Please Note:

1. Records requests cannot be filled on the same day.
2. Your request may take 5-7 business days to process.
   a. E-mail is the fastest method to receive records, but e-mail is not considered a secure form of communicating patient health information (please read the ***Important*** notice on the first page of this Authorization).
   b. Hard copies (paper or CD) may take up to three weeks to receive due to the high volume of campus-wide mail.
3. PDM will charge for records in accordance with a schedule of fees established by applicable state law.
4. If the patient has Medicaid, there is no fee. Please provide a copy of the front and back of your insurance card.
5. X-rays and Records will be printed on a CD unless printed copies are specifically requested.
6. Payment Options: The flat fee for records is $7.00
   a. **Cash**: In person only.
   b. **Credit Card**: All credit card payments must be made in person or online. Please access our Online Payment Portal here: https://inside.apps.dental.upenn.edu/apps/pay_online/
   c. **Check:** Make payable to: PENN DENTAL MEDICINE
7. Records released may contain information and images created and prepared by third parties not under control of PDM. PDM is not responsible for the content, accuracy or review of any such records.
8. PDM may deny this request under limited circumstances as provided for under federal law. PDM will notify you if it denies your request to access or obtain a copy of the requested information. If PDM denies this request, you may have the right to have a denial of your request reviewed by a licensed health care professional. To request such a review, please contact the University of Pennsylvania Chief Privacy Officer at the following address:

   Penn Medicine
   Office of Audit, Compliance and Privacy
   3819 Chestnut Street, Suite 214
   Philadelphia, PA 19104

PLEASE DO NOT WRITE BELOW THIS LINE

Record #_____ Processed By: _____
Date: _____