



Office for Registration and Records 801 S. Paulina, Room 105 Chicago, IL 60612 (312) 355-1984

**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

**\*\* There will be a fee for copies \*\***

**Patient Name:** \_\_\_\_\_ **Chart Number (if known):** \_\_\_\_\_  
(Last / First/ Middle)

**Patient Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Telephone:** (\_\_\_\_)\_\_\_\_\_

**I hereby authorize the Custodian of Dental Records at the University of Illinois at Chicago-College of Dentistry, to release my dental health records to:**

Person / Facility or Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please send my records sent electronically to email address \_\_\_\_\_

**Specific description of information that may be used/disclosed (check all that apply):**

Dental radiographs     Electronic treatment notes     Other (please specify) \_\_\_\_\_

**Dates of Treatment:** from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

**The information will be used/disclosed for the following purpose:**

Continuing Care     Personal     Legal     Other (please specify) \_\_\_\_\_

**I authorize the University of Illinois to release sensitive information as indicated:**

The patient 12 or over who consented to the treatment must authorize the release of sensitive information.

AIDS/HIV     Drug/Alcohol Abuse     Behavioral Health  
 Sexual Assault     Child Abuse     Developmental Disabiliti

I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

**I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. I understand that, if the persons or organizations I authorized above to receive and/or use the protected health information described above are subject to federal health information privacy laws, they may further disclose the protected health information and this information may no longer be protected by federal privacy laws and regulations.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Legal Representative Signature

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Relationship to Patient

If not otherwise specified, this authorization will expire within 90 days of the date of signature

**Return this form to the Office for Registration and Records in Room 103 or via fax (312) 413-0947**