Kornberg School of Dentistry
TEMPLE UNIVERSITY

Authorization To Release Records and Special Information

Full Name _____ **Date of Birth** _____ **Record #** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Phone Number _____

I hereby authorize Temple University Kornberg School of Dentistry to furnish information from my dental records to:

Name of Person/Office _____

Complete Address _____

Type of Access

This information I am authorizing to be disclosed will be used for the following purpose:

☐ Share with other health care providers as needed for treatment purposes

☐ My personal records ☐ Other (please describe)_____

I understand there will be a fee that must be paid prior to my receiving the photocopied records.

Specify nature and extent of information to be disclosed (check appropriate boxes)

☐ All of my health information that the provider has in their possession, including information relating to any medical history, mental or physical condition and any treatment received by me

☐ All of my health information described above except for the following (Check all that apply)

☐ Mental health status ☐ Substance/Alcohol abuse ☐ HIV status

☐ Other (please describe) _____

☐ X-rays only

Disclosure may include information relating to psychiatric, drug/alcohol and/or HIV or AIDS related information

This authorization is effective for the period from _____ to _____. If no expiration date is specified, it will expire 6 months from the date on which it was signed.

As required by the Health Insurance Portability and Accountability Act (HIPAA) you have the right to request the opportunity to inspect and copy health information that pertains to you. We will evaluate your request and will either grant it or explain the reason why the request cannot be granted. Your Right to access does not extend to information compiled in reasonable participation of, or for use in, a civil, criminal or administrative action or proceeding, or to information we received in confidence from someone other than the health care provider.

The authorization is subject to my revocation at any time by writing to the Patient Representative, Temple University Kornberg School of Dentistry.

I understand that the revocation will not apply to information already released in response to this authorization.

I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that once the information is disclosed, it may be redisclosed by the recipient and federal privacy laws or regulation may not protect the information.

I understand authorizing the use or disclosure of the information identified above is voluntary and that I do not need to sign this form to ensure healthcare treatment.

This authorization form has been fully explained to me and I certify that I understand its contents.

Patient Signature _____ Date _____

Witness_____ Signature of Witness _____

Note: Authorization must be signed by the patient or the next of kin in case of a minor or by legal guardian when the patient is physically or mentally incompetent. If authorization is signed by another than the patient, please state the reason: _____