School of Dental Medicine

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

Patient:

_____
Name

_____
Date of Birth

_____
Address

_____
City State Zip

_____
Phone #

Information to be Disclosed to:

_____
Name

_____
Address

_____
City State Zip

_____
Phone # Fax #

_____
Email

Information to be Disclosed / Released:

- ☐ Medical / Dental Information
  - Treatment Plan / Notes
  - Medical History
- ☐ Billing / Insurance Information

Information may be Released:

- ◯ During Patient Admission / Visit
- ◯ By Phone, Fax, or Email

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above via oral transmission. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed.

I understand that this consent expires **180 days from the date of my signature** unless otherwise specified as follows: _____ I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/ event of expiration, and that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax, or scan of this form is to be considered as valid as the original.

_____
Signature of the Patient /Authorized Representative

_____
Date of Signature

_____
Printed Name

_____
Relationship to Patient (If applicable)