Boston University Henry M. Goldman
School of Dental Medicine

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Boston, Massachusetts 02118
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General Authorization to Disclose Protected Health Information

Patient Name ______________________________ Date of Birth -______/______/________

I ____ (name of individual or personal representative) authorize the use or disclosure of the above named individual's Protected Health Information to:

Name of organization or person: ____

Address: ____

The purpose(s) for which disclosure is authorized:

□ for patient's personal records
□ sharing with other health care providers
□ other (please describe): _______________________________

I authorize use or disclosure of the following information (please note applicable duplication charges)
Check where applicable:

□ Paper Dental Record **Only** (inclusive of medical history, appointment notes, lab results, etc) - No charge

□ Radiographs **Only** (X-rays)
___ printed on diagnostic quality paper -$20
___ copied on a CD - $20

□ **Both** Paper Dental records and Radiographs
___ printed on diagnostic quality paper -$20
___ copied on a CD -$20

If you need records from a particular date/appointment only, please indicate date here: ______________________

I understand that my health record may include and I authorize disclosure of (check all that are applicable):

□ Information relating to Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.
□ Information about Sexually transmitted diseases
□ Mental health counseling and behavioral health notes
□ Information protected by 42 CFR Part II, federal laws protecting alcohol and drug abuse records.

I understand that:

1. I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee as mentioned above.
2. This Authorization is voluntary and that I have the right to refuse to sign it.
3. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy Practice; however such revocation would not affect any action taken by Boston University Goldman School of Dental Medicine in reliance on this Authorization before receipt of my written revocation.
4. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on whether I provide Authorization for any requested use or disclosure by Goldman School of Dental Medicine unless (a) the treatment is research related, (b) the information is needed for health plan eligibility or underwriting determinations, or (c) the sole purpose of creating the information is to disclose it to a third party.
5. This Authorization wi11 expire on: ______________________________or within 6 months whichever occurs first.
6. The information used or disclosed pursuant to this Authorization, except information protected by federal regulations about confidentiality of drug and alcohol abuse records, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws.

____ ____________________

Signature of individual/personal representative Date

____

If representative, relation to patient Signature

____ ____________________

Signature of Witness Date

Please note that it will take 10-12 business days for the duplication of records and X rays.

Office use only:

Release Received By ____________________________________Date_______________

X-rays/Records Duplicated By____________________________ Date_______________

Chart Number: ____________________________________