Boston University Henry M. Goldman School of Dental Medicine

Oral Surgery Group Practice

100 East Newton Street, Suite G407
Boston, Massachusetts 02118
Phone: 617-638-4350

General Authorization to Disclose Protected Health Information (PHI)~ Medical/Dental Record

Please Print clearly:

Patient Name _____ **Date of Birth:** _____/_____/_____

_____

Person authorizing disclosure: **I am (Circle one) the Patient, Parent of Patient, Legal Representative of Patient**
My Phone #:_____**My Email (optional) :** _____

My Address: _____
Street City State Zip

I, _____ authorize the use or disclosure of
(Printed Name of Patient, Parent or Legal Representative)
the above named patient's Protected Health Information to the following
Recipient:
Name of recipient individual or organization: _____
Contact person (if organization): _____
Recipient's Address: _____
Recipient's Email: _____

I would like this information to be disclosed by the following method (check one):
□ To me by mail to my above street address
□ Hold for Pick Up by me
□ To above-named Recipient by mail to Recipient's above street address
□ Hold for Pick Up by Recipient's above Contact person

The purpose(s) for which disclosure is authorized:
□ Personal
□ Insurance
□ Sharing with other health care providers
□ Legal Matter
□ Other (please describe): _____

I authorize use or disclosure of the following information (please note the applicable duplication charges for the requested services and *pay fees either by cash, check or credit card***)**
Check where applicable:

□ Medical/Dental Record **Only** (does not *include* radiographs) (includes medical history, appointment notes, lab results, etc.) - No charge

□ Radiographs **Only** (X-rays)
___ duplicates of radiographs -$25

□ Dental records* and Radiographs
___ duplicates of radiographs -$25

*** If you need records from particular dates/appointments only, please indicate dates here:**
From_____ **To** _____. **If you do not indicate above, your entire dental record will be released.**

Please note that it will take 3-4 weeks for the duplication of records and X- rays.

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.
□ Genetic testing information including test results.
□ 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. Subject to certain permitted exceptions, I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee as listed above. If access is denied, I will be given notice including the grounds for denial.
2. This Authorization is voluntary and 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 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 of Protected Health Information 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 will 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.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do expressly and voluntarily authorize disclosure of the above health records and information to those organizations or persons listed:

Signature of person authorizing disclosure:_____
Date signed: _____

Instructions:

Print (if necessary), sign and attach a copy of one form of your identification. *Legal representative must **also** provide documentation that allows you to act as a representative (e.g. guardian, executor, etc.) for the records being requested.*

Then, fax to 617-638-4365 or mail or deliver in person to 100 East Newton Street, Suite G407, Boston MA 02118

For Office use only

Date Received: _____Received by: _____

Date Released: _____Dental Record Number Released:_____

Check One:

□ **Mail to: _____** □ **Email to: _____**

□ **Pickup by (circle one):** Patient/ Personal Representative/ Recipient (or Recipient's contact Person)

Signature and ID provided by individual making pick up (check one):

□ License □ State ID □ Passport □ Other ID
□ Copy to accompany release and a copy placed into patient's record
□ Patient will be discontinuing their care at GSDM