GSDM DENTAL TREATMENT CENTERS

Authorization to Disclose Dental Records

PATIENT INFORMATION

Last Name/Surname | First Name | Middle Name | Date of Birth

Street Address | Apt. or Suite # | City | State | ZIP Code

Phone Number | Email Address | Fax Number

I AUTHORIZE GSDM TO SEND MY RECORDS TO (CHOOSE ONLY ONE)

☐ Me (To the email address provided above unless a different method is specified below)

☐ Someone Else

Name of Recipient or Organization permitted to receive information

Street Address | Apt. or Suite #

City | State | ZIP Code

Phone Number | Fax Number

Email Address

PURPOSE OF DISCLOSURE

☐ Personal Use ☐ Attorney ☐ Further medical care

☐ Other (Please explain):

RECORDS TO BE DISCLOSED

We always provide two years of X-rays, CBCT/CT scans, and progress notes. If you want a different time frame, a particular type of record (e.g., billing/financial statements or Perio charting), or a complete record, please indicate so in the Other box below.

☐ Other (Please explain):

DELIVERY OF RECORDS

We will provide your records electronically to the email address provided above unless you request another method here. Please Note: We will send you an electronic link to obtain your records that will be active for 30 days. During the 30 days, you will be able to download the requested records. After 30 days, the link will expire for security purposes.

☐ Other (Please explain):

RELEASE OF SENSITIVE INFORMATION

Please check YES, NO, or NA as to whether you want your records to include each of the types of sensitive information listed below. You need to mark YES and initial (where indicated) for this information to be released; otherwise, this information will be redacted and not disclosed (as applicable).

YES	NO	N/A		YES	NO	N/A		YES	NO	N/A	
☐	☐	☐	HIV Information/Test Results Specify Test Dates: _____ I specifically give permission to share my HIV test results and related information as required by Massachusetts state law. **Initial here:** _____	☐	☐	☐	Genetic Counseling/Screening Test Results. I specifically give permission to share my genetics testing/counseling information as required by Massachusetts state law. **Initial here:** _____	☐	☐	☐	Substance Use Disorder Patient Records (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.)
				☐	☐	☐	Domestic Violence				
☐	☐	☐	Sexually Transmitted Diseases	☐	☐	☐	Sexual Assault	☐	☐	☐	Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Health Clinician
☐	☐	☐	Information related to diagnosis or treatment of Pregnancy	☐	☐	☐	Human Trafficking				
				☐	☐	☐	Social Work Counseling/Therapy				

SIGNATURE

I understand that:

1. This Authorization is voluntary. GSDM does not condition treatment or payment for healthcare services on signing this Authorization. However, if I do not sign it, my records will not be released as directed in this Authorization.
2. This Authorization will expire after 6 months.
3. After signing this Authorization, I may revoke this Authorization at any time by providing written notice of revocation to GSDM (dentalrecords@bu.edu); however, any revocation will not affect disclosures made in reliance on this Authorization before receipt of my written revocation.
4. The information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws (except for Substance Use Disorder Patient Records).

I declare under penalty of perjury that I am the patient identified in this Authorization Form or the Legally Authorized Representative and that the information I am submitting is true and correct.

Signature of the individual or Legally Authorized Representative

Date

Name of Individual or Legally Authorized Representative

If Legally Authorized Representative, Specify Relationship to Patient

FOR OFFICE USE ONLY

Date Authorization Received

Received by (name, title)

Date Records provided

By (name, title)

VERIFICATION OF IDENTITY: CHECK ONE

☐ Patient or patient's friend/family picked up documents in person; I verified his/her identity.

☐ I mailed the records after verifying the name and address of the recipient.

☐ I emailed the link for the records after verifying the email address.

If Authorization is signed by the patient's Legally Authorized Representative, verify a copy of the court appointment or other documentation of the representative's authority. Contact the Office of the General Counsel or HIPAA Privacy Officer with questions.

☐ I verified the medical record contains documentation of the Legally Authorized Representative's authority.