



- My health record(s) will not be released or obtained unless permission is granted by my signature on this authorization.
- Only the record(s) checked above (front page) will be released for the stated reason(s).
- Although prohibited, it is possible that my PHI may be re-disclosed by the facility receiving my records, therefore, WVU Dental Corporation has no responsibility or liability as a result of the re-disclosure, and such information would no longer be protected by the HIPAA privacy rules.
- I am entitled to a copy of this completed authorization form.
- This authorization is valid for one year from the date of signature, unless a specific time frame less than one year is documented:  
Specified time from for validity: \_\_\_\_\_
- I have the right to revoke this authorization at any time by sending a written request to:  
UHA Dental Practice, PO Box 1587, Morgantown, WV 26507-1587  
Attention: Director of Clinical Education and Patient Care
- By revoking this authorization:  
My decision to revoke the authorization does not apply to any release of PHI that may have taken place prior to the revocation request.  
My decision to revoke the authorization may result in my insurance company not being able to pay for the medical care and I may be liable for payment of the claims.  
UHA Dental Practice cannot require me to sign the authorization in order to receive treatment
- This authorization may be revoked at any time by the patient. The revoking of this authorization shall not cancel any prior action that has transpired. This authorization shall remain valid for the production of specified records until the following date \_\_\_\_\_ or a period of 1 year from the date of form completion. **A new authorization will be required for any new visits to UHA Dental Practice that occur after the date of this authorization. Authorizations cannot be given for future visits.**
- NOTE: ADDITIONAL INFORMATION REGARDING HAND-CARRIED RECORDS OR MEDICAL INFORMATION INCLUDING AIDS, SEXUALLY TRANSMITTED DISEASE, HIV RELATED DISEASES, DNA SCREENING, BLOOD ALCOHOL CONTENT, ALCOHOL/SUBSTANCE ABUSE, ADOPTION AND/OR PSYCHIATRIC RECORDS ARE REQUESTED ON THE REVERSE SIDE OF THIS SHEET.

*UHA Dental Practice PO Box 1587 Morgantown, WV 26507-1587 304-293-1126 Fax 304-293-7646*