WEST VIRGINIA UNIVERSITY DENTAL CORPORATION d/b/a/
UHA DENTAL PRACTICE
Authorization for Release of Information

Date: _____ Record No._____

1. Patient Name _____
(Last) (First) (Middle Initial)

Address_____
(City) (State) (Zip)

Phone_____Birthdate_____SSN_____ (to be used if unable to find patient with name or date of birth)

2. This information is to be used for the purpose of:
☐Self ☐Insurance ☐Workers Comp ☐Disability ☐ Attorney ☐Dentist or other Health Care Provider

3. This information is to be:
☐ Mailed OR E-Mailed to Patient ☐ Hand Carried by_____
(Photo ID Required) –allow 24 hours for continued care; 7-21 days for other

☐ Mailed OR E-mailed to Dentist / Health Care Provider or as noted below (all information is to be completed below)

3A. _____
(Name / Facility / Agency) (**E-mail address**)

_____
(Complete Mailing Address) (City) (State) (Zip)

_____
(Phone Number) (Fax Number)

4. Release the following with photo static copies regarding my treatment: Required items must be checked.

_____Radiographic Images (CD of images) **(OR)** _____ Entire Dental Record

_____ Treatment Record _____ Other Images

_____ Pathology Reports _____ Itemized Billing Statement

Other (specific instructions) _____

Covering record time period from _____ to _____, I hereby release UHA Dental Practice from all legal liability that may arise from further disclosure of said records. (Required – Do not Date Ahead)

HIV – BEHAVIORAL HEALTH – DRUG ALCOHOL – PREGNANCY INFORMATION contained within the records indicated above will be released through this authorization unless otherwise indicated below. **(Any records containing any of this info requires signature from age 10 and older to sign for release of records)***

Do not release: _____ HIV _____Substance Abuse which includes (Alcohol – Drug Abuse) _____Pregnancy Information
_____ Behavioral Health/Psychiatric _____Sexually Transmitted Disease _____Other (Please List) _____

PLEASE READ: As of July 6, 2017, person(s) and companies requesting copies of healthcare records and radiology images for personal use will be charged according to West Virginia code 16-29-2 (2017). Requests will be pre-billed and payment received before records and images are released. West Virginia Code states that a health care provider may charge a $20.00 search fee along with 40 cents per page for paper records or 20 cents per page for electronic decumentation plus the costs of postage for copies of healthcare records. Our standard of delivery is CD electronic format for all medical records requests. The search fee will be waived for patients requesting records. **Please allow up to 30 days for processing**. Copies of records mailed to your health care provider will be provided at no charge.

_____ Date _____
(Signature of Patient Age 10 and up-Required)

_____ Date _____
(Signature of Legal Representative) (Relationship /Proof)

READ BACK OF FORM (over)

- 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 304-293-3511 Fax 304-293-7646

E-mail completed release to: sodrecords@hsc.wvu.edu