

**AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION - DENTAL**

(PLEASE PRINT CLEARLY)

<b>Patient Name</b> ( <i>Last, First, M.I.</i> )		<b>Date of Birth</b>
<b>Address</b>	<b>City</b>	<b>Zip Code</b>
	<b>State</b>	
<b>Phone Number</b>	<b>UNL ID / Other ID Number</b>	

<b>I authorize</b> ( <i>Provider/Facility Name</i> )		
<b>Phone Number</b>	<b>Fax Number</b>	
<b>Address</b>	<b>City</b>	<b>Zip Code</b>
	<b>State</b>	
To release my dental information to:	<b>University Health Center</b> <b>Attn: Dental Office</b> <b>1500 U Street</b> <b>Lincoln, NE 68588-0618</b>	<b>Phone: 402-472-7495</b> <b>Fax: 402-472-8010</b>

<b>I authorize the UNIVERSITY HEALTH CENTER to release my dental information to:</b>		
<b>Name</b> ( <i>Person/Organization</i> )		
<b>Phone Number</b>	<b>Fax Number</b>	
<b>Address</b>	<b>City</b>	<b>Zip Code</b>
	<b>State</b>	

Information to be requested/released		
<input type="checkbox"/> Dental Treatment Records	<input type="checkbox"/> Dental X-Rays	<input type="checkbox"/> Referral letter
<input type="checkbox"/> Other _____		

Method of Disclosure
<input type="checkbox"/> Fax
<input type="checkbox"/> Mail <i>CD is \$15</i>
<input type="checkbox"/> Will pick up

Purpose
<input type="checkbox"/> Dental Care
<input type="checkbox"/> Self
<input type="checkbox"/> Other _____
<input type="checkbox"/> Insurance
<input type="checkbox"/> Legal/Attorney

Date(s) of Service
From: _____
To: _____

This statement of consent can be revoked at any time before disclosure of the information, and expires on \_\_\_\_\_ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual /institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations.

I understand Nebraska Medicine and its affiliates will not condition evaluation or treatment on whether I sign this authorization.

Fees: I understand that federal and state laws allow a fee to be charged for the copying of medical records and I will be responsible for the payment of such fees.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Representative/Parent Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_



# University Health Center Record Receipt Acknowledgement



**(PLEASE PRINT CLEARLY)**

Date: \_\_\_\_\_

Time: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Print Name of Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Picture ID Verification: \_\_\_\_\_

UHC Representative Signature: \_\_\_\_\_