

University Health Center



AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION - DENTAL

Patient Name (Last, First, M.I.)		Date of Birth
Address	City	Zip Code
	State	
Phone Number	UNL ID / Other ID	Number
l authorize (Provider/Facility Name)		
Phone Number	Fax Number	
Address	City	Zip Code
	State	
· ·	Iniversity Health Center	Phone: 402-472-7495
	attn: Dental Office	Fax: 402-472-8010
	500 U Street	
L	incoln, NE 68588-0618	
I authorize the UNIVERSITY HEALTH CENTER to release	ase my dental information to:	
Name (Person/Organization)	Email	
Phone Number	Fax Number	
Address	City	Zip Code
	Stato	
	State	
Information to be requested/released		Mathad of Disalasura
-		Method of Disclosure
☐ Dental Treatment Records ☐ Dental X-Rays	☐ Referral letter	Fax
Other		☐ Email
	1) 1-	CD
Purpose	ate(s) of Service	☐ Will pick up
☐ Dental Care ☐ Insurance	om:	
☐ Self ☐ Legal/Attorney ☐ Fro	om:	
☐ Self ☐ Legal/Attorney ☐ Fro	om: To:	
☐ Self ☐ Legal/Attorney ☐ Fro		
☐ Self ☐ Legal/Attorney ☐ Fro		
Self Legal/Attorney From this statement of consent can be revoked at any time before	To:re disclosure of the information, and o	
Self Legal/Attorney From Different Consent can be revoked at any time before no expiration date or identifiable event related to the indiv	To: re disclosure of the information, and didual is listed, then the authorization	expires 12 months after it is signed.
Self Legal/Attorney Other This statement of consent can be revoked at any time befor no expiration date or identifiable event related to the indiv I understand that I may revoke this authorization at any time	To: re disclosure of the information, and of idual is listed, then the authorization he by notifying the providing organization.	expires 12 months after it is signed.
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University Health Center Record Receipt Acknowledgement



(PLEASE PRINT CLEARLY)

Date:	
Time.	
Patient Date of Birth:	
Print Name of Patient:	
Signature:	
Picture ID Verification:	
. Issue 15 Vermoduom	
JHC Representative Signature:	