University of Nebraska Lincoln

University Health Center

Nebraska Medicine

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION - DENTAL

(PLEASE PRINT CLEARLY)

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

I authorize *(Provider/Facility Name)*		
Phone Number	**Fax Number**	
Address	**City**	**Zip Code**
	State	
To release my dental information to:	**University Health Center** **Attn: Dental Office** **550 N 19th St** **Lincoln, NE 68588**	**Phone: 402.472.7495** **Fax: 402.472.8010**

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

Information to be requested/released

- ☐ Dental Treatment Records ☐ Dental X-Rays ☐ Referral letter
- ☐ Other _____

Method of Disclosure

- ☐ Fax
- ☐ Email
- ☐ CD
- ☐ Will pick up

Purpose

- ☐ Dental Care ☐ Insurance
- ☐ Self ☐ Legal/Attorney
- ☐ Other _____

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 of Nebraska Lincoln

University Health Center Record Receipt Acknowledgement

Nebraska Medicine

(PLEASE PRINT CLEARLY)

Date: _____

Time: _____

Patient Date of Birth: _____

Print Name of Patient: _____

Signature: _____

Picture ID Verification: _____

UHC Representative Signature: _____