Authorization for Use or Disclosure of Health Information - Dental

UNIVERSITY HEALTH CENTER
by Nebraska Medicine

Patient name: _____ Date of birth: _____
Last name *First name* *Middle initial*

Address: _____ City: _____ State: _____ Zip code: _____

Phone number: _____ NUID number: _____

☐ I authorize: _____
Name of provider/facility

Phone number: _____ Fax number: _____

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 DENTAL CLINIC to release my dental information to:

Name of provider/facility: _____

Phone number: _____ Fax number: _____

Address: _____ City: _____ State: _____ Zip code: _____

Information to be requested/released:

☐ Dental treatment records ☐ Dental X-rays ☐ Referral letter ☐ Other _____

Purpose:

☐ Dental care ☐ Insurance ☐ Legal/attorney ☐ Self ☐ Other _____

Dates of service: From: _____ To: _____

Method of disclosure:

☐ Fax ☐ Email ☐ CD ☐ Will pick up

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: _____ Date: _____

Relationship: _____