School of Dental Medicine

UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

Patient:

____
Name

____
Date of Birth

____
Address

____
City State Zip

____
Phone #

Information to be Disclosed to:

____
Name

____
Address

____
City State Zip

____
Phone # Fax #

____
Email

Information to be Disclosed / Released:

Medical / Dental Information
- Treatment Plan / Notes
- Medical History

Billing / Insurance Information

Information may be Released:

During Patient Admission / Visit

By Phone, Fax, or Email

AUTHORIZATION: I hereby give the releasing facility permission to disclose my individually identifiable health information as listed above via oral transmission. I understand that once this information is disclosed, it may no longer be protected. I understand that this authorization is voluntary, that further treatment cannot be conditioned upon my signing this authorization. I acknowledge that incomplete forms cannot be processed.

I understand that this consent expires **180 days from the date of my signature** unless otherwise specified as follows: ______________________ I understand that I can take back permission to release my medical records at any time, except to the extent that action has already been taken to comply with it. I understand that I must provide notice in writing if I choose to revoke this authorization before the date/ event of expiration, and that the written revocation must be signed and dated with a date that is later than the date on this authorization. A copy, fax, or scan of this form is to be considered as valid as the original.

____
Signature of the Patient /Authorized Representative

____
Date of Signature

____
Printed Name

____
Relationship to Patient (If applicable)