School of Dental Medicine
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

Authorization to Release Dental Information

The University Of Colorado School Of Dental Medicine will provide copies of dental records when requested in writing and paid for by the patient. Records are released consistent with the following:

- Requests MUST be made in writing and be signed and dated by the patient. Use of this form is not required, but will facilitate processing of requests.
- Payment for requested records MUST accompany written requests or be received prior to processing for requests.
- Payment for all treatment rendered at SDM is expected prior to the release of records.
- Requests may take 5-10 business days to be processed after receipt of completed request(s) and applicable fees.
- A form of ID will be requested at the time of pick up. If someone other than the patient will pick up the record, a written and signed statement by the patient identifying the person is necessary with a form of ID.

Patient name:_____ Patient Date of Birth:_____

Patient's Identification Number (if known):_____ Last Date of Treatment: _____

The requested information (name of doctor, hospital, person, agency, or organization where records should be sent):

Name: _____

Address: _____

Email (for digital records):_____

Program/Clinic where treatment was provided: (check all that apply)

☐Student Clinic ☐General Practice Residency ☐Advanced Periodontal Therapies
☐Orthodontic Program ☐Faculty Practice ☐Emergency Clinic

Purpose(s) or need for which information is to be used:

☐Transfer of Care ☐Second Opinion ☐Other (describe) _____

INFORMATION/RECORDS REQUESTED	**Fee**
☐ **Treatment progress notes and most recent treatment plan**	**$10.00 per request/ $0.00 digital**
☐ **Full mouth series, panoramic, ceph radiographs (x-rays)** ☐ Printed (mailed or picked up) ☐ Digital (email)	**$20.00 for printed/ $0.00 digital**
☐ **1-4 intraoral (periapical or bitewings)** ☐ Printed (mailed or picked up) ☐ Digital (email)	**$5.00 printed/ $0.00 digital**
☐ **Cone BEAM CT;** digital/email option not available ☐ Printed (mailed or picked up) ☐ CD (mailed or picked up)	**$30.00 per request (digital not available)**
☐ **Photocopy other written forms**	**.10 per page min $5.00/ $0.00 digital**
☐ **Mailing/processing fee (unless picked up)**	**$5.00 per request**
TOTAL FEE:	_____

Checks should be made payable to University of Colorado School of Dental Medicine

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AUTHORIZATION

I request and authorize the University Of Colorado School Of Dental Medicine to release the information specified above to the organization, agency or individual names on this request. I understand that unless I direct otherwise in WRITING, the information to be released may include information regarding the following condition(s) if any; psychological or psychiatric condition; sickle cell anemia, drug abuse, alcoholism or alcohol abuse. I certify that this request has been made voluntarily and the information given above is accurate the best of my knowledge. I understand that I may revoke this authorization at any time, except the extent that action has already been taken to comply with it. Re-disclosure of my dental records by those receiving the above authorized information may not be accomplished without my further written consent. This consent will automatically expire upon satisfaction of this request by the Dental School.

Date_____ **Signature of Patient/Guardian**_____