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 signed and dated by the patient. Use of this form is not required, but will facilitate processing of requests.
  Forms should be e-mailed to: SDMRecords@ucdenver.edu, or mailed to CU School of Dental Medicine-13065 East 17th Avenue, Aurora, CO 80045-c/o Patient Records Department.
- Applicable fees must be received prior to processing
- Requests may take up to 7 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 an ID.

Patient name: _____ Date of Birth: _____
Information where records should be sent (name of doctor, hospital, person, agency, or organization)
Name: _____Phone Number_____
Address: _____
Email (for digital records): _____

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

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

Information/records requested	**Fee**	
(Checks made payable to University of Colorado School of Dental Medicine)		
☐ Treatment progress notes	☐ $0.00 for digital	☐ $10.00 printed
☐ Most recent treatment plan	☐ $0.00 for digital	☐ $10.00 printed
☐ All current x-rays	☐ $0.00 for digital	☐ $20.00 printed
☐ Cone BEAM CT: (digital/email NOT available)	☐ $30.00 per request	☐ $5 mailing

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 to the best of my knowledge. I understand that I may revoke this authorization at any time, except to 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_____

Version: 7/11/2022