UTHealth Houston | School of Dentistry

Health Information Management
Release of Records
7500 Cambridge Street, Suite 1332
Houston, TX 77054
Phone: 713-486-4254 | Fax: 713-486-4322

At UTHealth Houston School of Dentistry, we are dedicated to maintaining a high level of privacy and confidentiality with all patient dental records. We keep all health information private and secure in accordance with federal and state regulations.

A patient or guardian/legal representative may request a personal copy of the patient's dental records or request transfer of dental records to another party.

1. Complete the **Consent for Release of Patient Records** form.
2. The patient or guardian/legal representative must fill out the form.
3. Submit completed form by one of the following options:
   - Visiting UTHealth Houston School of Dentistry - Health Information Management
   - Mailing to 7500 Cambridge Street, Suite 1332, Houston, TX 77054
   - Faxing directly to 713-486-4322
   - Emailing to dentalrecords@uth.tmc.edu
4. A valid photo ID is required to process all requests for release or transfer of records.
5. A fee may apply for duplication and transfer of records (TAC Rule 108.8).

First 20 pages	$25.00
Per page, thereafter	$0.15
Each full mouth radiograph series (FMS), panoramic or lateral cephalometric radiograph	$15.00
Each single extra/intra-oral radiograph	$1.00
Each CBCT scan	$30.00

We will notify the patient or guardian/legal representative upon receipt and will process requests within 30 days of receiving all required information, including applicable fees.

For additional information, please call **UTHealth Houston School of Dentistry - Health Information Management** at (713) 486-4254. Hours of operation are Monday - Friday, 7:30 a.m. to 11:30 a.m. and 12:30 p.m. to 4:00 p.m.

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Consent for Release of Patient Records

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SECTION A: PATIENT INFORMATION

Last Name: ____________ First Name: ____________ Middle Name: ____________

Other Preferred Name Used: ____________ Date of Birth: ____________

Address: ____________ City: ____________ State: ____________ Zip Code: ____________

Phone: ____________ Email: ____________

SECTION B: SELECT INFORMATION TO BE RELEASED

Covering the period(s) of dental treatment: From ____________ To ____________

☐ Complete dental records (including, but not limited to, information regarding medical history, dental treatment, radiographs, general ledger, billing statements, consents, and referral documents)

☐ Limited dental records: (Select type of records to be release):

- ☐ Billing (General Ledger and Statements)
- ☐ Dental Treatment Notes
- ☐ Radiographs/Images
- ☐ Reports (Pathology or Radiology)
- ☐ Other: (specify) ____________

SECTION C: RELEASE INFORMATION TO

I am authorizing release of this information to:

Name of Recipient and/or Entity: ____________

Address: ____________ City: ____________ State: ____________ Zip Code: ____________

Phone: ____________ Fax: ____________

Email: ____________

Purpose(s) of Release: (Select all that apply)

☐ Dental Care ☐ Insurance ☐ Legal/Attorney ☐ Personal

☐ Other: (specify) ____________

Method of Release: (Select only one option below)

☐ Email ☐ Fax (no radiographs) ☐ Mail ☐ Pick up in person

SECTION D: CONSENT NOTICE AND SIGNATURE

1. I understand that this release may include information regarding communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care, unless specifically requested to be omitted.
2. I understand that requests for copies of dental records are subject to fees in accordance with federal and state regulations.
3. I understand this consent expires in 90 days unless expressly revoked by me. I understand that I may withdraw this authorization by submitting a written, dated request, and that such revocation does not affect action that already has been taken based on this authorization.
4. I understand that UTHealth Houston School of Dentistry may not defer treatment based upon this request.
5. I understand that to the extent any recipient of this information, as identified above, is not a “covered entity”, any disclosure of information carries with it the potential for unauthorized re-disclosure, and the information may be not protected by federal or Texas privacy laws.

____________ ____________ ____________

Patient or Guardian/Legal representative — Date — Relationship, if NOT the Patient

**Authorized Guardian/Legal representative may be requested to show proof of representative status*

Internal Use Only:

Received Date: __________ Date Sent: __________ Initials: __________ # of pages: __________ / # of radiographs: ______

E.H.R. #: __________