

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](mailto: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).

### **Fees**

A fee of \$20 will be applied for duplication and transfer of records (digital or paper). In addition, a fee of \$30 per disk for Imaging (Pano, FMS, CBCT) will be applied.

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.

### 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. #: \_\_\_\_\_