UTHealth | School of Dentistry
The University of Texas
Health Science Center at Houston
Phone: 713-486-4254 Fax: 713-486-4322

# Consent for Release of Patient Record

**PATIENT INFORMATION:**

I hereby authorize UTHealth School of Dentistry to release information from the dental record(s) of:

_____

This release may include information regarding communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), Psychiatry, Drug, and/or Alcohol Abuse, unless specifically requested to be omitted.

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

Chart #: _____ Birth Date: _____ Age: _____ Gender: Female
Male

**INFORMATION TO BE RELEASED:**

Progress notes only
Images only
Billing
Complete dental record

This information is to be released to□□

Name: _____ Phone Number: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

**AUTHORIZATION:**

I understand this authorization expires □C 5□□□□□□□ unti V ekpRessly 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.

| _____ | _____ | _____ |
|---|---|---|
| Patient's Name | Patient's or Responsible Party's Signature | Date |

E-mail
Mail
Pick-up

| _____ | _____ | _____ |
|---|---|---|
| Name of Signer, if not Patient | Relationship to Patient | Method of Release |