

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

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

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 School of Dentistry-Health Information Management at (713) 486-4254. Hours of operation are Monday-Friday, 7:30 a.m. to noon and 1-4 p.m.

SECTION A: PATIENT INFORMATION

Name: _____ DOB: _____ EHR#: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Telephone: _____ 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) Radiographs Progress Notes

Other: _____

SECTION C: RELEASE INFORMATION TO

I am authorizing release of this information to:

Name of Recipient and/or Entity: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Telephone: _____ Fax: _____

Email: _____

Method of Release: (Select only one option below):
 Email Mail Fax – Progress Notes Only 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 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

Internal Use Only:
 Received Date: _____ Date Sent: _____ Initials: _____ # of pages: _____ / # of radiographs: _____