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).

<table>
<thead>
<tr>
<th>Description</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 20 pages</td>
<td>$25.00</td>
</tr>
<tr>
<td>Per page, thereafter</td>
<td>$0.15</td>
</tr>
<tr>
<td>Each full mouth radiograph series (FMS), panoramic or lateral cephalometric radiograph</td>
<td>$15.00</td>
</tr>
<tr>
<td>Each single extra/intra-oral radiograph</td>
<td>$1.00</td>
</tr>
<tr>
<td>Each CBCT scan</td>
<td>$30.00</td>
</tr>
</tbody>
</table>

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: __________