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).

**Fees**

A fee of $20 will 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

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>Middle Name:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Other Preferred Name Used: Date of Birth:

<table>
<thead>
<tr>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
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</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name of Recipient and/or Entity:</th>
<th>Address:</th>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
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</table>

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 that 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. #:

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(8/2022)