UCLA Dentistry

Dear Patient,

Enclosed is an AUTHORIZATION FOR THE RELEASE OF DENTAL RECORDS (Protected Health Information).

Please complete the form and return it by mail to:

WestWood:

UCLA Dental Clinics
Custodian of Records
10833 Le Conte Ave.
CHS 10-138, School of Dentistry
Los Angeles, CA 90095
Phone: (310) 825-3195
Fax: (310) 825-7620

Venice:

Venice Dental Center
323 S Lincoln Boulevard
Venice, CA 90291
Phone: (310) 392-4103
Fax: (310) 392-8513

There is a $16 fee for copies of your written records. If you're requesting radiographs there is an additional fee of $16 per copy.

Please make your check payable to **The Regents of the University of California**. You may also make a credit card payment over the phone.

Yours sincerely,

UCLA Dental Clinics
Custodian of Records

UCLA Dentistry

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PATIENT DENTAL RECORDS

I request and authorize the UCLA Dental Clinics to release and disclose the patient health records of_____ _____as follows (please check option that applies):

☐ Send a physical copy of the patient records and/or radiographs by mail to the person/entity and address listed below:

_____ _____
Name Patient's Date of Birth

_____

☐ Disclose my patient health information to:

Name: _____ Relationship: _____

☐ Notify me by telephone at ____when a physical copy of the patient records and/or radiographs is ready to be picked up

NATURE OF THE INFORMATION TO BE RELEASED

I request and authorize the UCLA Dental Clinics to release and disclose the following patient records (ple ase check all that apply):

Full Information	***Partial Records***	***Partial Radiographs***
☐ All dental records	☐ Treatment Plan Only	☐ Full-Mouth Set
☐ All radiographs	☐ Progress Notes Only	☐ Bitewings
	☐ Orthodontic Study Models	☐ Individual Periapical
	☐ Test/Lab Results	☐ Panoramic
	☐ Billing Records	☐ TMJ Views
		☐ PA Cephalometric
		☐ Lateral Cephalometric
		☐ Three-Dimensional Scans
☐ Other:		

_____

TREATMENT PERIOD

I request that the patient records to be released cover the following time period (please check and enter dates):

☐ From _____ to _____

☐ All

SPECIFIC AUTHORIZATIONS

The following patient information will not be released unless you specifically authorize disclosure by checking the applicable box(es) below:

☐ I specifically authorize the release and disclosure of information pertaining to drug and alcohol abuse, diagnosis, or treatment. (42 C.F.R. *§§* 2.34 and 2.35).

☐ I specifically authorize the release and disclosure of information pertaining to mental health diagnosis or treatment. (Welfare and □Institutions Code §§ 5328, et seq.).

☐ I specifically authorize the release and disclosure of HIV/AIDS test results. (Health and Safety Code § 120980 (g)).

☐ I specifically authorize the release and disclosure of genetic testing information. (Health and Safety Code § 124980 (j)).

REVOCATION OF AUTHORIZATION

The UCLA Dental Clinics usually process a request for release and disclosure of patient records within seven (7) business days of receiving this authorization. You may revoke this authorization at any time ***before*** the above request has been processed by sending written notice to:

<u>WestWood:</u>
General Clinic Director
UCLA Dental Clinics
Custodian of Records
10833 Le Conte Ave.
CHS 10-138, School of Dentistry
Los Angeles, CA 90095
Phone: (310) 825-3195
Fax: (310) 825-7620

<u>Venice:</u>
Venice Dental Center
323 S Lincoln Boulevard
Venice, CA 90291
Phone: (310) 392-4103
Fax: (310) 392-8513

The revocation will take effect upon receipt of your request by the UCLA Dental Clinics, except to the extent that the UCLA Dental Clinics have already relied on the authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization will expire on _____ (*insert applicable date or event*). If no date is indicated, this authorization will expire 12 months after the date of signing this form.

_____ _____

Patient Signature (Area Code) Phone Number

_____ _____

Patient Name Date

OR

_____ _____

Patient's Representative Signature Relationship

_____ _____

Patient's Representative Name Date

If signed by Patient Representative, please check box in front of reason below.

- ☐ Patient is a minor.
- ☐ Patient is legally incompetent to sign.
- ☐ Patient is unable to read English, but consent for Authorization for release of Patient Health Records was translated verbally for the patient, and the patient has given his/her verbal consent.
- ☐ Patient is physically incapable of signing, but has given his/her verbal consent.