

Dear Patient,

Enclosed is an AUTHORIZATION FOR THE RELEASE OF RADIOGRAPHS VIA E-MAIL.

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

Please note that only digital radiographs can be e-mailed. Radiographs taken prior to the implementation of digital radiography cannot be e-mailed.

Please also note that most popular email services (ex. Hotmail, Gmail, Yahoo, Outlook) do not utilize encrypted email. When we send your radiographs to you or you send us an email, the information will be transmitted via unencrypted email. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

E-mails regarding your care are considered part of your dental record.

There is a **nominal fee** for the processing of digital radiographs.

Yours sincerely,

UCLA Dental Clinics
Custodian of Records

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF RADIOGRAPHS VIA E-MAIL

I, _____, understand the risks of unencrypted email and Authorize the UCLA Dental Clinics to release and disclose my radiographs electronically via unencrypted email to my email address listed below:

Email address

Date of Birth

NATURE OF THE INFORMATION TO BE RELEASED

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

<input type="checkbox"/>	Full-Mouth Set
<input type="checkbox"/>	Bitewings
<input type="checkbox"/>	Individual Periapical
<input type="checkbox"/>	Panoramic
<input type="checkbox"/>	TMJ Views
<input type="checkbox"/>	PA Cephalometric
<input type="checkbox"/>	Lateral Cephalometric
<input type="checkbox"/>	Other:
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

TREATMENT PERIOD

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

<input type="checkbox"/>	From _____ to _____
<input type="checkbox"/>	All

REVOCACTION 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:

Westwood:

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

Venice:

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

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 the consent for Authorization of disclosure of Radiographs by Email 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.