CWRU Dental Clinic General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please provide the following information:

Patient Name:

Address:

Phone:

Date of Birth:

Email:

I authorize Case Western Reserve University School of Dental Medicine to release the following information: (Indicate records you are authorizing for release with a check.)

X-Rays (indicate dates requested): Progress Notes Treatment Plans

I agree to pay $12.00 per sheet of copy for x-ray duplication.

Send via email I understand email communication is not protected by federal privacy regulations.

Records to be sent to the following:

Name:

Address:

Phone: Fax:

In order for records to be picked up at the school, one of the following forms of ID is required.

Driver's License #: Social Security #:

I Understand that:

- **After the custodian of records discloses my health information, it may no longer be protected by federal privacy regulations. Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.
- Case School of Dental Medicine is authorized by this document to release the above information.
- I may see and obtain a copy of the information described on this form if I request it, and that I will receive a copy of this form after I sign it.
- A new release form will need to be signed for subsequent requests.
- I may refuse to sign this authorization. If I refuse to sign this authorization, I will be required to pick up the records in person and present valid picture identification. My health care and payment for my healthcare will not be affected if I do not sign this form.

This authorization is for one time only and expires 90 days from the date written below. I may revoke this authorization at any time before records are sent by providing written notice to Case School of Dental Medicine, 10900 Euclid Avenue, Cleveland, Ohio 44106-4905.

I will be returning to the Case School of Dental Medicine ☐ Yes No

A copy of this form was given to this patient. ☐ Yes No

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Signature of patient or guardian & relationship to patient

Completed and signed form must be uploaded at:

SCHOOL OF DENTAL MEDICINE
CASE WESTERN RESERVE UNIVERSITY

This form approved by CWRU Legal Department 01/02/2018