AUTHORIZATION TO RELEASE PATIENT INFORMATION

Carolina Dentistry
First in care. For the people.

UNC ADAMS SCHOOL OF DENTISTRY
PATIENT RECORDS
TARRSON HALL CB#7450
CHAPEL HILL, NC 27599-7450

PHONE: (919) 537-3515 FAX: (919) 537-3625

I AUTHORIZE THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL ADAMS SCHOOL OF DENTISTRY, ITS AGENTS AND ITS EMPLOYEES TO RELEASE PROTECTED HEALTH INFORMATION ABOUT ME / MY CHILD TO THE RECIPIENT BELOW, WHICH MAY INCLUDE ALCOHOL AND DRUG ABUSE TREATMENT; PSYCHOLOGICAL AND SOCIAL WORK COUNSELING; HIV, AIDS AND ARC; COMMUNICABLE DISEASES OR INFECTIONS, INCLUDING SEXUALLY TRANSMITTED INFECTIONS, TUBERCULOSIS AND HEPATITIS; AND DEMOGRAPHIC INFORMATION; FOR THE PURPOSES AND UNDER THE CONDITIONS DESIGNATED ON THIS FORM.

PATIENT INFORMATION

First Name	Last Name		Date of Birth
Street Address	City, State	Zip Code	Phone Number

DELIVERY OPTION (Choose only one)

☐ **SEND BY MAIL OR FAX TO:**

Recipient *(Self or Name of Provider/Other Entity)*

Address

City, State, Zip Code

Phone Number Fax Number

☐ **SEND BY ENCRYPTED EMAIL TO:**

Recipient Phone Number

E-mail Address

☐ **CALL FOR PICK-UP**

Tarrson Hall, Room B0022

Self or Name of Representative Phone Number

INFORMATION TO BE DISCLOSED:

	DATES
☐ X-Rays/Imaging	From ________ to __________
☐ Exam and Treatment Notes	From ________ to __________

Other Information: ______________________________________

PURPOSE(S) FOR DISCLOSING INFORMATION:

- ☐ Continuation of Care/Consultation
- ☐ Social Security/Disability Certification
- ☐ Workers Compensation
- ☐ Attorney Inquiry/Legal Matter
- ☐ Insurance Claim/Application
- ☐ Other

REVOCATION AND REDISCLOSURE: I understand that I may revoke my authorization in writing to the Carolina Dentistry Patient Records Office. Carolina Dentistry can rely on this authorization until it is revoked or until conditions are met. I understand that once my information has been disclosed, it may no longer be protected from subsequent disclosures by federal or state privacy laws.

ELIGIBILITY NOT AFFECTED: I understand that signing this authorization is voluntary. My treatment will not be conditioned upon my signing or refusing to sign this document.

TIME FRAME: Please allow a period of 10 business days to process and complete your request.

SIGNATURE:________________________________ **DATE:**____________________

AUTHORIZATION SIGNED BY A LEGAL REPRESENTATIVE MUST INCLUDE A COPY OF THE GUARDIANSHIP PAPERS OR POWER OF ATTORNEY