MUSC
JAMES B. EDWARDS COLLEGE of DENTAL MEDICINE

Fax completed form to:
843-792-7009
Email completed form to:
cdmimages@musc.edu

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Form Origination Date: 1/2000
Version: 7 Version Date: Rev 05/15

This form must be completed in its entirety in order to be considered valid.

Patient Name: _____ Date of Birth: _____

Dental Record Number (if known): _____ Email address: _____

I authorize the MUSC College of Dental Medicine to ☐ release information ☐ obtain information from:

Name of Individual / Organization: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number _____

Disclosure Purpose: ☐ Continued care ☐ Legal ☐ Insurance ☐ Disability ☐ Patient Request

☐ School ☐ Military ☐ Other _____

Date(s) of service requested: _____

☐ Films / images ☐ Dentist progress / visit notes ☐ Entire record

☐ Other: _____

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I authorize the exchange of this information via **(choose one)**: ☐ Mail or ☐ Fax or ☐ Other: _____

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Dental Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from this date or _____.

I understand that fees for copies of medical records and postage fees may be charged as provided by S.C. Law.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. I understand I will be given a copy of this authorization.

A copy of my identification will be made and attached to this authorization.

_____ _____
Signature of Patient or Legal Guardian / Representative Date

_____
Printed Name of Patient or Legal Guardian / Representative

_____ _____
Relationship to Patient, if signed by Legal Guardian / Representative Witness Signature

Document(s) of patient representative's authority must be attached if patient is not signing.

To contact Dental Health Information Services (Dental Records) in writing, the address is: 29 Bee St./DC 606/MSC 507/Charleston, South Carolina 29425-3490; the phone number is (843) 792-2225. Fax number is (843) 792-7009.

Original to Dental Health Information Services (dental records department) Copy to patient