AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL INFORMATION

HEALTH SCIENCE CENTER
TEXAS A&M UNIVERSITY

3000 Gaston Ave, Dallas, TX 75226 (Primary Location)
4570 Scyene Rd, Dallas, TX 75210 (Second Location)
Mailing Address - 3302 Gaston Avenue, Dallas TX 75246
Fax 214-874-4552

Privacy Notice: The information on this form together with any attachments is the property of Texas A&M Health (TAMH). State Law requires that you be informed that you are entitled to: (1) request notification of the information collected about you by use of this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge to you.

Instructions: Please note that each section of this form must be completed in its entirely. Failure to specify (including dates) will delay the processing of your request. Allow 14 Business Days for Processing. Email completed form to COD-Records@tamu.edu

PATIENT	**Patient Last Name**	**Patient First Name**	**Patient Middle Name**	**Date of Birth**
RELEASED FROM	**Name/Organization**	**Email Address**	**Phone**	
	Texas A&M College of Dentistry	COD-Records@tamu.edu	214-828-8217	
	Address	**City, State, Zip Code**	**Fax**	
	3000 Gaston Ave	Dallas, TX 75226	214-874-4552	
	Information may be: ☐ **Mailed** ☐ **Faxed** ☐ **Phoned** ☐ **Emailed** ☐ **Picked up by Name:** _____			
RELEASED TO	**Name/Organization**	**Email Address**	**Phone**	
	Address	**City, State, Zip Code**	**Fax**	
PURPOSE	**Records are to be released for the following purpose(s): (Select all that apply)**			
	☐ **Dental Care** ☐ **Personal**			
	☐ **Insurance** ☐ **Legal/Attorney** ☐ **Other (specify):** _____			
Visit Date(s):	**Provide the Visit Date(s) or Date Range of Services for the request:** _____			
INFORMATION TO RELEASE	**Indicate types of records to be released : (Select all that apply)**			
	☐ **Full Dental Record** ☐ **Financial Records** ☐ **Radiology/Imaging Reports**			
	☐ **Appointment History** ☐ **Progress Notes** ☐ **Radiology/Imaging Photos**			
	☐ **Other (specify):** _____			

PATIENT/ PARENT/LEGAL GUARDIAN AUTHORIZATION

Unless otherwise revoked, the Authorization will expire 60 days from the date it is signed or, if specified, on the following date: _____. This Authorization may be revoked at any time. In order to revoke the Authorization the individual/parent/legal guardian must submit a revocation request in writing to the Office of Clinical Affairs at the primary location address above.

I, the undersigned, hereby authorize Texas A&M Health (TAMH) to use and/or disclose information from my (or below given relationship) medical/dental or financial record as specified above. This authorization includes the use and/or disclosure of information concerning HIV testing, any drug record or alcohol abuse, drug-related conditions, alcoholism, and/or mental health conditions to the above mentioned entity(ies). I agree not to hold TAMH, its employees, agents, officers, members, students, and participating health care providers responsible for lost, stolen, or otherwise misplaced medical/dental information that cannot be reproduced. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the parties who receive my information and may no longer be protected by federal or state privacy laws. I understand that the method in which I have chosen (above) for my information to be released may or may not be secure.

Signature of Patient: _____ Date: _____

By signing the below, I verify that I have legal right(s) to obtain the requested medical/dental information for the patient listed above.

Signature: _____ Relationship: _____ Date: _____

OFFICE USE ONLY	**Request completed by: (PRINT NAME)**	**Signature**	**Date/Time**
	Released by: (PRINT NAME)	**Signature**	**Date/Time**
	Witness (If released via telephone)	**Signature**	**Date/Time**