THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

College of Dentistry
3039D Postle Hall#10
305 West 12th Avenue
Columbus, OH 43210-1267
Phone: 614-292-5757
Fax: 614-247-8011

Authorization Request for Release of Information

Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164

Please complete all sections as incomplete forms will not be processed

Patient Name: _____	Date of Birth: ____/____/____	Last 4 digits of Social Security Number: _____	Telephone Number: (____)____-____

Authorization for release of PHI covering ☐ from (date) _____to (date) _____ **OR** ☐ all records

YOU ARE REQUESTING:
(Please mark all that apply)

- ☐ Radiographs
- ☐ Dental Records
- ☐ Implants information

HOW TO RECEIVE YOUR INFORMATION:

- ☐ **Pick up** my copies:
  Office of Clinic Administration Room 1130
  Postle Hall
- ☐ **Mailed** to the name and address below
- ☐ **Emailed** to the address below
- ☐ **Faxed** to the name and phone number below

SUBMIT THIS REQUEST TO:

Mail: Dentistry Records Request #10
3039D Postle Hall
305 W. 12th Ave
Columbus, Ohio 43210-1267
Fax: (614) 247-8011
Drop Off: Office of Clinic Administration
Room1130 Postle Hall

EMAIL copies to:

_____

FAX copies to:

Name: _____

Fax Number: **(____)____-____**

MAIL copies to:

Name:_____

Address:_____

_____

_____

The following fees may be assessed for duplicated materials per Ohio Revised Code 3701.741:
Pages 1-10: $3.51/page **Pages 11-50:** $0.73/page **Pages 51 or more**: $0.29/page **Radiographs:** $2.41/page **Compact Disk**: $5.00

I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact than an HIV test was performed. Information in the form of audio, photo, or video has been designated above, if applicable. I expressly consent to the release of information designated above. The authorization is valid for 365 days, from the date executed, unless revoked by my written notice, provided said notice is received prior to release of the above designated information.

The revocation of this authorization is effective except as indicated in Ohio State University College of Dentistry Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA**.** I understand that Ohio State University College of Dentistry cannot condition my treatment or payment for healthcare on this Authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

_____ _____
Printed Name of Patient or Person Authorized to Consent — Relationship to patient

X_____ _____
Signature — Date

FOR CLINIC ADMINISTRATION USE ONLY	
Request Received: _____ **Patient ID:** _____ **Record Location:** _____	**Notes**: _____ _____

Under HIPAA Rule 164.524, the College of Dentistry has 30 days from the receipt of this form to complete your request.