UNIVERSITY OF MINNESOTA
Driven to Discover℠

UNIVERSITY OF MINNESOTA | SCHOOL OF DENTISTRY | RELEASE OF RECORDS

STEP 1: ENTER PATIENT INFORMATION:

Patient Name (Last, First, and MI):	Date of Birth (MM/DD/YYYY):
Phone:	Chart #:

STEP 2: SELECT DESIRED SERVICE: ☐ Dental Records Only ☐ Dental X-Rays Only ☐ Dental Records and X-rays

STEP 3: ENTER WHERE YOU WOULD LIKE THE INFORMATION SENT: (Please select one)

☐ **SEND BY MAIL TO** (5-7 business days)

Name: _____

Address: _____

Suite/Apt #: _____

City/State: _____

Zip Code: _____ Phone: _____

☐ **SEND BY EMAIL TO** (2-3 business days)

Name: _____

E-mail: _____

☐

STEP 4: REASON FOR REQUEST: _____

STEP 5: SIGN BELOW: (PATIENT OR LEGAL REPRESENTATIVE SIGNATURE)

I understand the following:

1. The information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.
2. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. This authorization may be revoked by providing written notice to: University of Minnesota School of Dentistry, ATTN: Privacy Officer, 8-434 Moos Health Sciences Tower, 515 Delaware Street, S.E., Minneapolis, MN 55455.
3. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal law.
4. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
5. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
6. This authorization will expire 1 year from the date signed below.

By signing below, you agree that you understand and accept the terms on this form. You give the University of Minnesota School of Dentistry permission to have your records copied, picked up, mailed or electronically sent to the indicated party above.

SIGNATURE: _____ **DATE:** _____

STEP 6: SUBMIT THE SIGNED RELEASE FORM IN ONE OF THESE WAYS:

MAIL:	FAX OR EMAIL:	DROP OFF:
University of Minnesota School of Dentistry Department of Primary Dental Care 515 Delaware Street S.E., Room 9-426 Minneapolis, MN 55455	Fax: 612-624-9270 Email: ucaremdc@umn.edu	Moos Tower (School of Dentistry Room 9-426)

Questions? Please call UCare's Mobile Dental Clinic (612-624-5654)

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