UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

Baltimore
650 W. Baltimore Street
Baltimore, MD 21201
410-706-7101

RECORDS RELEASE REQUEST

Date: _____/_____/_____ Duplication Fee (Office Use Only): $_____ Chart Number (Office Use Only): _____

Patient Name: (Please print clearly): _____ Patient DOB: _____/_____/_____
First M.I. Last

As required by the Health Insurance Portability and Accountability Act of 1996, the University of Maryland Dental School may not use or disclose your health information without your authorization except as provided in our Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for the uses and disclosures described below.

If other than patient, print the name of the person requesting release of dental records on behalf of the patient named above, and specify relationship to patient.

Requestor's Name: _____ Relationship to patient: _____
First M.I. Last

By signing below I give permission to the University of Maryland School of Dentistry to release copies of (check one):

☐ My dental records ☐ My child's dental records ☐ The dental records of the patient named above whom I am legally authorized to represent

I authorize and request the records to be released/sent to: (please print clearly)

Name: _____

Address: _____
Street City State Zip Code

I understand that:

- I have the right to request a copy of this form after I sign it, as well as inspect or copy any information to be used and/or disclosed under this authorization.
- If the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- A copy of the patient record will be released. The original patient record remains the property of the University of Maryland School of Dentistry and will be maintained in accordance with Maryland state laws.
- I will be charged a fee for duplication of the information.

I authorize and request the release of the following information (please check all that apply):

PLEASE NOTE: ADMINISTRATIVE FEES ARE AS FOLLOWS: $.76 PER PAGE AND $5.00 PER SET OF X-RAYS.
(I.E. FULL MOUTH SERIES, BITEWINGS & PAN ARE $5.00 EACH)

Dental record (treatment notes, Perio Charting)	**Dental X-rays & other images**
☐ Last 2 years	☐ Last 2 years
☐ Full History	☐ Full History

To request a copy of your Financial History or Treatment Plans, please contact the business manager of your current clinic office. (Additional fees will apply.)

Processing your request for copies of records and radiographs (X-rays) takes approximately **TEN (10) WORKING DAYS AFTER RECEIPT OF THE AUTHORIZATION FORM AND PAYMENT**. **Please make check payable to University of Maryland and send to the attention of Dental Records Supervisor**. **To reach us by telephone, call 410-706-3437 or fax to 410-706-6280**.

Patient or Requestor's Signature Date