UCI Student Health Center

Authorization for Release of Dental Information

This authorization for the use or release of medical information is requested from you in order to comply with the requirements of California Civil Code Section 56, et seq.

_____ ____/____/____ _____ (____) _____
Patient Name (Last, First MI) **DOB** **UCI ID#** **Cell Phone Number**

_____ _____ _____ _____
Address **City** **State** **Zip Code**

Authorization: I hereby authorize the release of my medical records:

FROM:

University of California, Irvine
Student Health Center Dental Clinic
500 East Peltason Drive
Irvine, CA 92617

TO:

☐ Private Dentist: _____ ☐ Patient
Address: _____ email: _____
Phone Number: _____

LIMITATIONS & COST of COPYING & HANDLING:
The information to be released is limited to:

- ☐ Dental records only - **$15**
- ☐ Retrieve archived dental records - **$20** (Additional cost)
- ☐ Dental records with X-rays - **$40**
- ☐ X-Rays only - **$25**
- ☐ Other (specify): _____ (Cost to be determined)

PURPOSE OF RELEASE:
Please check one of the following boxes:

- ☐ Personal Records
- ☐ Specialist Referral
- ☐ Will seek treatment at a private dentist
- ☐ Second opinion
- ☐ Student graduated
- ☐ Other: _____

I understand that the requester may not further use or disclose this dental information unless another authorization is obtained from me, unless such disclosure is specifically permitted by law.

I further understand that I have a right to receive a copy of this authorization, upon request,
Copy requested & received:

- ☐ Yes
- ☐ No

This authorization is effective immediately and shall remain effective until ____/____/____
(This authorization will expire in 6 months after the date signed unless specified.)

Signed: _____ Date: ____/____/____

For Dept. Use Only. ☐ Mailed ☐ emailed ☐ Faxed ☐ Hand Carried by Pt.
Date Completed: _____ Initials: _____