NYU DENTISTRY

Dental Faculty Practices

Where Academics Meets Clinical Excellence

Authorization for Release of Health Information

The NYU Dentistry Notice of Privacy Practices (NPP) describes how medical information about you may be used and disclosed and how you can get access to this information. We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, **we must obtain your written authorization before we may use or disclose your health information for the purposes you will have the opportunity to describe**. This form provides that authorization.

Instructions: Complete this form and submit it in person at NYU Dentistry, or by mail to:

Attn: Health Information Management Office (Medical Records)
NYU College of Dentistry
345 East 24th Street, Room 501
New York, NY 10010

You also have the option to submit a copy of this completed form to dental.records@nyu.edu, or sign this release electronically at your point of care at the NYU Dental Faculty Practice. Contact your care team for assistance with this process and/or alternative options to submit your request if none of the above options are accessible to you.

Mental Health / Substance Abuse / HIV Information
Please be advised that if your health records contain information relating to any of the below conditions, you have the right to restrict the release of this information.
- Alcohol/Drug Treatment
- HIV-Related Information and test results
- Mental Health Treatment (except psychotherapy notes)

If this applies to you, download and complete New York State DOH Form 5032. A printed copy is available upon request through a representative at your point of care or by e-mail to dental.records@nyu.edu.

Date of request: _____

SECTION A: PERSON WHOSE INFORMATION WILL BE RELEASED

First name: _____ **Last name**: _____

Date of birth:: _____ **Chart number** (if known): _____ ☐Unknown

Telephone number: _____ ☐Mobile ☐Landline **E-mail:** _____

SECTION B: RECORDS REQUESTED (select all that apply)

☐ All records on file. ☐All records from a specific date range: _____

☐Treatment notes	☐All on file	☐Specific date range: _____
☐Radiographs/images (x-rays, photos)	☐All on file	☐Specific date range: _____
☐Cone-beam (CBCT)	☐All on file	☐Specific date range: _____
☐Oral pathology (biopsy) report	☐All on file	☐Specific date range: _____

☐Other forms/documents (specify): _____

Continued on next page

Use the space below to provide any additional detail pertaining to your request (optional)

SECTION C: REASON FOR DISCLOSURE OF INFORMATION

☐ Personal/At my request ☐ Legal ☐ Other (specify below)

SECTION D: METHOD OF DELIVERY (select all that apply)

☐ **Paper copy** ☐ Arrange for pick-up ☐ Send by mail *(specify address below)*

☐ **Digital device** (e.g. flash drive) ☐ Arrange for pick-up ☐ Send by mail *(specify address below)*

☐ **Encrypted Electronic Mail** *(specify e-mail address)*: _____

☐ **Other.** If none of the methods listed above are accessible or acceptable to you, contact your care team at NYU Dentistry or e-mail dental.records@nyu.edu to discuss alternative solutions.

I give authorization for the health information detailed in section B of this document to be shared with the following individual(s) or organization(s):

Name/Office: _____

Organization *(if applicable):* _____

Mailing address: _____

SECTION E: DURATION OF AUTHORIZATION

This authorization is valid for one (1) year after the date of request, unless otherwise specified below:

☐ 1-year after date of request ☐ One-time release only ☐ Specified duration: _____

AUTHORIZATION

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

- Duplication of records may take up to ten days to be processed.
- The person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.
- I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to: Health Information Management Office (Medical Records), NYU Dentistry, 345 East 24th Street, New York, NY 10010, or by e-mail to dental.records@nyu.edu.

My questions about this form have been answered and the required information is completed.

Signature of Patient or Personal Representative **Date**

If signed by a personal representative, printed name and description of representative's authority: