NYU DENTISTRY

NYU Faculty Practice
726 Broadway
Suite 350
NY, NY 10003

222 E 41st Street
Floor 22
NY, NY 10017

Patient Name: _____ **Chart #:** _____

Address: _____ **Phone:** _____

_____ _____

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 described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

Please read the information below carefully before signing this form

I, or my authorized representative, request health information regarding my care and treatment at NYU Faculty Practice to be released by NYU Faculty Practice to the party named below.

Please be advised that if your health records contain information relating to any of the following conditions:

- Alcohol/Drug Treatment
- HIV-Related Information and test results
- Mental Health Treatment (Except psychotherapy notes)

New York State requires a separate written authorization for release of this information.

Please inform the Manager of the Clinic you are assigned to or are being treated in if you need to sign the New York State (NYS) authorization form.

I, , authorize NYU Faculty Practice to duplicate and release my radiographs/dental treatment record to the designated party indicated below. I understand that duplication of records may take up to ten days to be processed.

All requests for record duplication must be presented to the manager of the clinic you are assigned and are being treated in at the Faculty Practice. Request by mail or fax must be notarized.

1. **Name(s) and address(es) of person(s) who will be receiving this information:**

2. **Records Requested:**

☐ All radiographs and treatment notes and health realted forms:

Radiographic Films:
- ☐ CBCT Scans
- ☐ Full Mouth Series/Additional Periapical/Bitewings
- ☐ Panormaic
- ☐ Cephalometric

Period of Treatment Date(s):

3. **Reasons for disclosure of information:**

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Chart #:** _____

Address: _____ **Phone:** _____

_____ _____

4. **Method of delivery:**
   - ☐ Will pick up/call when duplicated
   - ☐ Email to provider/legal
   - ☐ Mail when duplicated
   - Email address: _____

5. **Date or event that will trigger the expiration of this authorization:**
   - ☐ One time only
   - ☐ 3 months
   - ☐ 6 months
   - ☐ 9 months
   - ☐ One year
   - ☐ Event

Specify event (must relate to patient or purpose for disclosure):

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and send my written revocation to:

NYU College of Dentistry
Medical Records
345 East 24th Street, Room 407WA
New York, NY 10010

I understand that the revocation will not apply to information that has been already been released to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that the information disclosed, may be re-disclosed if the recipient(s) describe in this form is not required by law to protect the privacy of the information, and the information is no longer protected by health information privacy rules.

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

Signature of patient, parent, or guardian	Name of patient, parent, or guardian	Relationship to Patient	Date

UPON REQUEST, THE PATIENT OR AUTHORIZED REPRESENTATIVE WILL BE PROVIDED WITH A COPY OF THIS FORM AFTER IT HAS BEEN SIGNED.

NYU Dental Center Use Only:

Date Received: ____/____/____ Date Processed: ____/____/____

Notations _____

Name of Staff Member Processing This Request: _____