

**WEST VIRGINIA UNIVERSITY DENTAL CORPORATION
AUTHORIZATION FOR RELEASE OF INFORMATION**

Patient Name:	Date of Birth:	Social Security No. (optional):
Provider's Name: WVU Dental Corporation	Provider's Address: PO Box 1587 Morgantown WV 26507-1587	Provider's Phone: 304-293-3511 Provider's Fax: 304-293-7646
Recipient's Name:		
Recipient's Address:		
City:	State:	Zip:
Recipient's Phone, Email, and Fax:		
Phone: _____	Email: _____	Fax: _____
Select One - Disclosed information is to be: <u> </u> Mailed <u> </u> Emailed <u> </u> Faxed		
This authorization will expire in 1 year (365 Days) unless otherwise specified:		
Description of information to be used or disclosed		
Check all that apply: Entire Dental Record: _____ Treatment Record: _____ Date(s): _____ Pathology Report: _____ Date(s): _____ Radiology Report: _____ Date(s): _____ Radiographic Images (x-rays) _____ Date(s): _____ Other Images: (please specify) _____ Date(s): _____ Itemized Billing Statement: _____ Date(s): _____ Other records (please specify): _____		
I acknowledge, and hereby consent to such, that the release of information may contain pregnancy, alcohol, drug abuse, psychiatric, HIV or AIDS information. _____ (initials)		
I understand that: - I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, information described above may be re-disclosed to other individuals or institutions and no longer protected by these regulations. - I understand that I may inspect and receive a copy of this authorization. - I understand that WVU Dental Corporation will not refuse to treat me simply because I do not sign this authorization. - I understand that I may revoke this authorization at any time in writing except where action has already been taken in reliance upon this authorization.		
Written revocation may be sent to PO Box 9401, Morgantown, WV 26506-9401. By revoking this authorization: Decision to revoke the authorization does not apply to any release of information that may have taken place prior to the revocation request. Decision to revoke an authorization may result in your insurance company not being able to pay for care, and you may be liable for payment of claims.		
I have read the above and authorize the disclosure of the protected health information as stated. In accordance with state law, a minor patient's consent may be required for certain medical records: Unless otherwise indicated below, a patient age 10 and older must sign for release of records in the event such records contain any information related to pregnancy, alcohol/drug abuse, psychiatric treatment, and HIV/AIDS or STDs.		
Signature of Patient or Legal Representative: _____ Date: _____		
Printed Name of Patient or Legal Representative: _____		
Relationship to Patient: _____		

completed forms can be emailed to SODRecords@hsc.wvu.edu or faxed to (304) 293-7646.