THE OHIO STATE UNIVERSITY
COLLEGE OF DENTISTRY

College of Dentistry

1082 Postle Hall #174
305 West 12th Avenue
Columbus, OH 43210-1267
Phone: 614-292-5757
Fax: 614-247-8011

Authorization Request for Release of Information

Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164
Please complete all sections as incomplete forms will not be processed.

PATIENT NAME: ______________________________	**DATE OF BIRTH:** ______/______/______
ADDRESS: ______________________________	**LAST 4 DIGITS OF SOCIAL SECURITY NUMBER:** ______________
______________________________	**PHONE NUMBER:**______________

Under HIPAA Rule 164.524, the College of Dentistry has 30 days from the receipt of this form to complete your request.

YOU ARE REQUESTING:
- ☐ Radiographs
- ☐ Dental records
- ☐ Radiographs and dental records

HOW TO RECEIVE YOUR INFORMATION:
- ☐ I want to pick up my copies
- ☐ I want my copies mailed to my address above
- ☐ I want my copies mailed to the dentist/business's address below:

WHERE TO SUBMIT YOUR REQUEST:
By mail:
Dentistry Records Request # 174
1082 Postle Hall
305 W 12th Avenue
Columbus, Ohio 43210-1267
By fax: 614-247-8011
Drop off: Clinic Administration Office 1130 Postle Hall

DENTIST/BUSINESS: ____

ADDRESS: ____

Have you received copies of your radiographs and dental records from the College previously? ☐ **Yes** ☐ **No**
The following fees will be assessed for previously duplicated materials:
Pages 1-10: $3.11/page **Pages 11-50:** $0.65/page **Pages 51 and higher:** $0.26/page **Radiographs:** $2.13/page

Authorization for release of PHI covering: ☐from (date) _____ to (date) _____ **or** ☐ all past and present records

Per Ohio Revised Code 3701.741, you may be charged a fee for copies of medical (dental) records.
I hereby authorize the treatment facility indicated above and its employees to release the designated information contained in my patient record or designated record set. I understand and acknowledge that this authorization extends to all or part of the information designated above, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include results of an HIV test or the fact than an HIV test was performed. Information in the form of audio, photo, or video has been designated above, if applicable. I expressly consent to the release of information designated above. The authorization is valid for 365 days, from the date executed, unless revoked by my written notice, provided said notice is received prior to release of the above designated information.
The revocation of this authorization is effective except as indicated in Ohio State University College of Dentistry Notice of Privacy Practices. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA**.** I understand that Ohio State University College of Dentistry cannot condition my treatment or payment for healthcare on this Authorization unless the treatment is research-related or the care was provided solely to provide information for a third party.

X______________________________________ ______________________
Signature of Patient or Person Authorized to Consent **Date Signed**

X______________________________________ ______________________
Relationship, if not the patient **Date Signed**

FOR CLINIC ADMINISTRATION USE ONLY	
Request Received: ______________ **Patient ID:** ______________ **Record Location:** ______________	**Notes**: ______________________________________ ______________________________________