AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name:_____ ID#_____ Date of Birth_____

I give permission for the Montana State University Dental Clinic to release my personal health and dental information as described below to the following:

Name:_____

Address:_____

Phone #_____
Fax: _____

Records to be: emailed _____ mailed_____ phone calls _____ patient will pick up_____

Dates of Treatment:_____

The information for which I am authorizing disclosure will be used for the following purpose:
_____Personal records
_____Continuing treatment with other health care providers

- I understand that this authorization is voluntary, and that I may revoke the authorization at any time by presenting my written revocation to the MSU Dental Clinic. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that if the recipient is not a health plan or health care provider covered by federal privacy regulations, the released information may no longer be protected by federal privacy regulations.
- This authorization will expire in six months unless stated otherwise.
  Date to discontinue._____
- **I understand that this may include information regarding HIV/AIDS, sexually transmitted diseases, mental health status or treatment for alcohol and drug abuse.**
- I understand by authorizing this use or disclosure of information, there will be no conditions placedon my health care or payment for my health care.

By signing below, I understand and acknowledge the following:

- That I have read and understand this authorization
- If I have any questions about disclosure of my protected health information, I may contact the MSU Dental Clinic..

Signature of Patient:_____Date:_____

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