UNIVERSITY OF MINNESOTA | SCHOOL OF DENTISTRY | RELEASE OF RECORDS

STEP 1: ENTER PATIENT INFORMATION:

Patient Name (Last, First, and MI):	Date of Birth (MM/DD/YYYY):
Phone:	Chart #:

STEP 2: SELECT DESIRED SERVICE: ☐ Dental Records ☐ Dental X-Rays ☐ Dental CBCT SCAN

STEP 3: ENTER WHERE YOU WOULD LIKE THE INFORMATION SENT

☐ **MAIL CBCT** (5-7 business days) **$15 FEE**	☐ **EMAIL Records/X-rays** (2-3 business days)
Name: ______	Name: ______
Address: ______	E-mail: ______
Suite/Apt #: ______	
City/State: ______	☐ **PICK UP CBCT disc $15 FEE**
Zip Code: ______ Phone: ______	(7th Floor Front Desk Mon-Fri 10am-12pm, 2pm-4pm)

STEP 4: REASON FOR REQUEST: ______

STEP 5: SIGN BELOW: (PATIENT OR LEGAL REPRESENTATIVE SIGNATURE)

I understand the following:

1. The information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.
2. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. This authorization may be revoked by providing written notice to: University of Minnesota School of Dentistry, ATTN: Privacy Officer, 8-434 Moos Health Sciences Tower, 515 Delaware Street, S.E., Minneapolis, MN 55455.
3. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal law.
4. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
5. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
6. This authorization will expire 1 year from the date signed below.

By signing below, you agree that you understand and accept the terms on this form. You give the University of Minnesota School of Dentistry permission to have your records copied, picked up, mailed or electronically sent to the indicated party above.

SIGNATURE: ______ **DATE:** ______

STEP 6: SUBMIT THE SIGNED RELEASE FORM (AND PAYMENT IF APPLICABLE) IN ONE OF THESE WAYS:

MAIL:	**FAX OR EMAIL:**	**DROP OFF:**
University of Minnesota School of Dentistry 515 Delaware Street S.E. - Room 16-205E Minneapolis, MN 55455	Fax: 612-625-3227 E-Mail: dentxray@umn.edu	Moos Tower (School of Dentistry) 7th Floor Front Desk

PAY BY MAIL: check only. PAY BY PHONE: (612-625-2495) credit card only. PAY IN PERSON: cash, check, or credit card at any front desk. PAY ONLINE: visit dentistry.umn.edu/patients/pay to pay via our secure payment processing portal.

Questions? Please call Health Information Management 612-625-3980

Revised 9-6-2023