Print Form

Student Health Center
University of California · Irvine

Authorization for Release of Dental Information

This authorization for the use or release of medical information is requested from you in order to comply with the requirements of California Civil Code Section 56, et seq.

PLEASE PRINT:

Patient Name (Last, First MI)			D.O.B.	UCI Student/Staff ID
Address	City	State	Zip Code	Telephone Number

Authorization: I hereby authorize the release of my medical records:

FROM:

University of California, Irvine
Student Health Center Dental Clinic
501 Student Health Rm. 175
Irvine, CA 92697-5200
(949) 824-5307
Fax: (949) 824-1884

TO:

__ Private Dentist: _____ __ Patient
Address: _____
Phone Number: _____

LIMITATIONS:
The information to be released is limited to:

__ All Dental records
__ X-Ray Report(s): _____
__ X-Ray Film(s): _____
__ Other (specify): _____

PURPOSE OF RELEASE: Please check one of the following boxes:

__ Personal Records
__ Specialist Referral
__ Will seek treatment at a private dentist
__ Second opinion
__ Student graduated
__ Other: _____

I understand that the requester may not further use or disclose this dental information unless another authorization is obtained from me, unless such disclosure is specifically permitted by law.

I further understand that I have a right to receive a copy of this authorization, upon request,
Copy requested & received:

__ Yes
__ No

This authorization is effective immediately and shall remain effective until _____.
(This authorization will expire in 6 months after the date signed unless specified.)

Signed: _____ Date: _____

For Dept. Use Only. *Rec. No.:* ☐ *Mailed* ☐ *Faxed* ☐ *Hand Carried by Pt.*
Date Completed: *Initials:*