axiUm record number:

AUGUSTA UNIVERSITY
DENTAL COLLEGE OF GEORGIA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Last 4 digits of SSN: _____
Address: _____ Date of Birth: _____
City/State/Zip: _____ Daytime Phone #: _____

Address: AU Dental College of Georgia, Business/Records Office, GC-1001, Augusta, 1120 15th Street, GA, 30912
Records Request Contact Number (706) 721-9447

I authorized the facility indicated above to use or disclose the above named individual's health/dental health/related financial information as described below concerning the period from _____ to _____.

☐ Medical and Dental Health Information, as specified:
- ☐ Treatment Records (copying charges may apply)
- ☐ Most Current X-Rays (copying charges may apply)

☐ Entire Medical/Dental Record (justification required) (copying charges may apply)

_____

☐ Financial or Other Records (Specify) _____

☐ Psychiatric/Psychological Information ☐ Drug/Alcohol Abuse Treatment Information ☐ HIV/AIDS Information

This information may be disclosed to and used by the following individual or organization:
Format: ☐ Printed or ☐ Electronic ☐ Mailed or ☐ For Patient or Legal Representative Pick-up only or ☐ Verbal disclosure

Name: _____

Address: _____City/State/Zip: _____ Phone _____

Purpose: _____

Special instructions: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the AU Dental College of Georgia Business Office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I fail to specify an expiration date, event or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health/dental information, I can contact the Augusta University Enterprise Privacy Officer at (706) 721-5631.

_____ _____ _____
Signature of Patient or Legal Representative Date Time

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

Return completed authorization form to the above Business Office address.

Rev. 10/2017