AUTHORIZATION for DISCLOSURE

SAINT LOUIS UNIVERSITY

Dental Specialties of Saint Louis University

Dental Specialties of
Saint Louis University
3320 Rutger Street
St. Louis, MO 63104
314.977.8363

I authorize Dental Specialties of Saint Louis University to release the following information:

Patient's Name/Previous Names:

_____

_____

Birth Date | Social Security Number | Patient ID#

RECIPIENT (person or organization that will receive your information)

_____

(Doctor/Hospital/Attorney/Insurance Company/Self/etc.)

_____

Address (Street, City, State, ZIP Code) | Phone Number

DESCRIPTION of INFORMATION to be RELEASED

Check items that apply:

- ☐ All Dental Specialties of Saint Louis University Records – Orthodontic Clinic, excluding models
- ☐ All Dental Specialties of Saint Louis University Records – Endodontic/Periodontic Clinic
- ☐ All Records (including outside provider records)
- ☐ Invisalign Trays #d _____ to _____

Specific Information Only (May list specific incident or identify body region)

- ☐ Summary of Dental/Medical History/Treatment
- ☐ Laboratory/Diagnostic Tests
- ☐ Consultations
- ☐ Pathology Report(s)
- ☐ Radiology Report(s)
- ☐ Operative Report(s)
- ☐ Progress Notes
- ☐ Models
- ☐ Invisalign Trays
- ☐ Illness or Injury
- ☐ Prescriptions
- ☐ X-Rays
- ☐ Billing Information
- ☐ Other _____

Date(s) of Service: _____

Records from Specific Provider(s): _____

Body Region/Incident: _____

Note: This authorization does not allow release of original radiology films, pathology slides.

PURPOSE of DISCLOSURE

☐ Continuing Dental Care	☐ Legal Purposes
☐ Social Security/Disability	☐ Insurance
☐ School	☐ Patient's Request
☐ Military	☐ Other _____

I understand that the specific information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including human immunodeficiency virus, (HIV) and acquired immune deficiency syndrome (AIDS), or specific information which requires release by a minor. I also understand that this authorization may be revoked by the person giving authorization by a written and dated notice.

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that fees may be associated with this request for dental information.

EXPIRATION

This authorization expires on the following date, event, or special condition.

_____

(Dates of service after signature date will not be released.)

APPROVAL **(You or your Personal Representative must sign and date this form for completion.)**

Patient:

Patient Representative: The person who has legal authority to act on behalf of the individual. A copy of a Healthcare Power of Attorney or other legal document must be on file or submitted with this form.

_____ (Print Name)	_____ (Printed Name of Personal Representative)	
_____ (Signature)	_____ (Signature of Personal Representative)	
_____ (Date)	_____ (Date)	_____ (Description of Authority)

NOTICE OF REVOCATION

I, _____, hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Patient: _____ Date: _____

Personal Representative: _____ Date: _____