UCF | Student Health Services

Dental Center
4098 Libra Drive, Orlando, FL 32816-3333
Tel (407) 823-1635 Fax (407) 823-5140

Authorization to Release Dental Records

Dental Record/Images: ○ All / ○ Specific date: _____

Format: ☐ **Pick up** ☐ **Mail** ☐ **Fax** ☐ **Telephone** ☐ **Consent to discuss in person**
☐ **Paper** ☐ **CD** ☐ **Flash Drive** ☐ **Email**

Entity Releasing Information	**Entity Receiving Information**
Name: **University of Central Florida** **Student Health Services Dental Services**	Name: _____ Relationship:_____
Address: **PO Box 163333 Orlando FL 32816-3333**	Name: _____ Relationship:_____
Phone: **(407) 823-1635 Fax: (407) 823-5140**	Name: _____ Relationship:_____
	Email: _____

Purpose of Disclosure: Continuity of Care ☐ **Other**_____

- I understand if the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy laws and may be redisclosed.
- I understand that I may ask and get a copy of this authorization after I sign it.
- UCF Student Health Services may not deny treatment, payment, enrollment or eligibility for benefits based on whether or not I sign this authorization.
- **I understand that this authorization will expire 12 month from date signed unless another date is specified for continuous exchange of information. Expiration Date: _____**
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions UCF Student Health Services took before they received the revocation.

****IF NOT SIGNED IN PERSON FORM MUST BE NOTARIZED BELOW IN THE WITNESS SECTION****

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____ UCF ID# _____

_____ _____
Signature of Parent or legal Guardian (when applicable) Date

_____ _____
Witness Name & Signature Date

Revocation of Authorization

I, _____, would like to revoke this authorization as of: _____

Signature to Cancel: _____

******CONFIDENTIALITY NOTICE*******

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Faxed By: _____ Mailed By: _____ Hand Carried By: _____ Emailed By: _____ Date: _____