CSU HEALTH NETWORK
COLORADO STATE UNIVERSITY

CSU Health Network
Medical Records
970-491-4124
970-491-0226 (fax)

Authorization for Disclosure of Dental Records

_____ _____

Patient's Last Name First Middle Date of Birth

_____ _____

Student ID Number Patient's Phone Number

I hereby authorize CSU Health Network Dental Services to release information to:

_____Myself* _____Other-specify **NAME:** _____

*I understand there will be a processing charge **ADDRESS:** _____

for releasing my records to myself _____

Information to be Released

PHONE: _____

☐ A copy of Dental Record Notes, Dental Charting Record and Oral X-rays. (If Available)

☐ X-ray only (Specify what X-ray) _____

I acknowledge that the information to be released may include information regarding the diagnosis or treatment of HIV (AIDS virus) or other sexually transmitted diseases, mental health or psychiatric treatment, or drug and alcohol education and treatment records. I give my specific authorization to release all health care information relating to such diagnosis, testing or treatment.

Purpose or Need for Information

___ Consultation Referral **___Care Provider** **___Personal Records**

___Insurance Claim **___Attorney** **___ _____**

I certify that this authorization has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this in writing at any time, except to the extent that action has already been taken to comply with it. Without my express revocation this consent will automatically expire upon satisfaction of the need for disclosure, not to exceed 1 year from the date of signature. I understand that this authorization will not apply to care provided after date of my signature. I release CSU Health Network from liability and claims of any nature pertaining to the disclosure of requested information contained in my medical records.

_____ _____

Date **Patient Signature**

This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal Regulation (42CRF, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.