MITMedical

Dental Service
77 Massachusetts Ave., E23-528
Cambridge, MA 02139-4307
Phone: 617-253-1501
Fax: 617-258-5500

Authorization for Release of Protected Health Information (PHI) — Dental Record

Important information about releasing patient dental records

MIT Medical recognizes the patient's right to confidentiality of protected health information as set forth in federal and Massachusetts state law. You should be aware of these guidelines when requesting dental records.

State and federal laws recognize the need for written authorization.
All releases based on this form are limited to records dated up to and including the date of the patient's signature. A new authorization is necessary for release of information on care provided after the date of the patient's signature, unless you (the patient or personal representative) state in the authorization to release future records of a specific test, specific clinic appointment, etc.

If the patient is 18 years or <u>older</u>, the patient *must* sign the release unless:

1. the patient is incompetent,
2. the patient is disabled and cannot sign the form, or
3. the patient is deceased. (The surviving spouse or legal representative with legal proof must sign the authorization for release of the deceased patient's records.)

If the patient is 18 years or <u>younger</u>, the patient *must* sign the release if:

1. the patient is an MIT student, regardless of age
2. the patient is 14 years or older **and** the records involve treatment for mental illness, alcoholism, drug dependence, or AIDS testing, **or**
3. the patient's records for release include an abortion procedure.

Anyone other than the patient who signs this authorization for release of records must state their relationship to the patient and provide proof of legal authority to release the records.

Please read before completing the form on the next page:

- This form must be completed in its entirety and signed by the patient or personal representative to be a valid authorization. Incorrect or incomplete forms will not be processed.
- The MIT Dental Service does not fax records.
- If you wish to have the information disclosed to you directly, there is a prepayment fee of $10. The fee may be paid using cash, check, Visa, Discover or MasterCard.
- There is no fee for records released directly to other healthcare providers.
- When copies of the dental record are requested for parties other than the patient, the recipient of the record will be charged a $15 base fee.
- If you wish to complete this form in person at MIT Medical's Dental Service, make sure to bring two forms of ID. One must be a government ID (driver's license, state ID, or passport). If you have any questions or need more information, please call the Dental Service at 617-253-1501.
- To obtain a copy of test results, procedure and/or notes that were done at another health care organization, please contact that organization directly.

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1. PATIENT INFORMATION

Patient last name _____ First name _____ MI _____ Date of birth _____

Patient former name (if any) _____ MIT ID _____

Patient address _____ Patient e-mail _____
Street City State Zip

Patient home phone _____ Work phone _____ Cell phone _____

2. RECIPIENT AUTHORIZATION

I, _____, do hereby authorize _____ to release a copy of my
Patient name or representative Provider or service (e.g., "MIT Medical")

dental record to the person or facility below.

(Please note: If records are released directly to you, a $10 prepayment fee is required. MIT Medical does not fax records.)

Name of person or facility to receive dental record _____ Street address _____

City, state, ZIP _____ Phone _____

3. INFORMATION TO BE RELEASED

☐ Entire dental record: _____ ☐ Full mouth series (FMX): _____ ☐ Panoramic X-ray: _____

☐ Bite wings: _____ ☐ Individual X-ray #: _____

4. PURPOSE OF INFORMATION RELEASE

☐ Further dental care ☐ Payment of insurance claim ☐ Legal investigation ☐ At the request of the individual

☐ Other (specify): _____

5. INCLUSION OF PRIVILEGED INFORMATION

I understand that if my record contains information relating to abortion, HIV testing and related information, AIDS or an AIDS-related condition, alcohol abuse, drug abuse, mental health, genetic testing, STD, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111 §70, such information will be included in this disclosure.

If you do **not** wish to have released any of the categories of information described above, please specify: _____

_____

6. PATIENT RIGHTS AND PRIVACY

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to MIT Medical's Dental Service, except to the extent that the Dental Service has already completed action on it.
- I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release the MIT Medical from all legal responsibilities and liabilities that may arise from the release of such protected health information.
- I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of six months, and it automatically expires six months after the date this form is executed.

7. SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____ Date _____
Signature

Personal representative, print name _____
Printed name of personal representative

If signed by anyone other than the patient, state the relationship to patient and/or reason and legal authority for signing:

Patient is: ☐ incompetent ☐ disabled ☐ deceased

Legal authority: ☐ parent ☐ legal guardian ☐ next of kin of deceased

For MIT Medical use only

Date rcvd: _____ **Rcvd by** _____ **ID provided:** _____ **MRN:** _____

Date released: _____ **Processed by:** _____ ☐ **Sent by mail** ☐ **Picked up in person**