UB DENTAL

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO NYS LAW

(This form has been approved by the NYS Department of Health)

Patient Name: _____ Date: _____
MR#: _____ Account #: _____ DOB: _____
Patient Address: _____
_____
Telephone Number: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. In accordance with New York State Law, I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. If the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize the release of such information to the person(s) indicated in Item 7.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493.
3. I have the right to revoke this authorization at any time by writing to the health care provider or entity listed in section 6. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might by disclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer by protected by federal or state law.
6. Name and address of health care provider or entity to release this information: SUNY, University at Buffalo, School of Dental Medicine, 325 Squire Hall, Buffalo, NY 14214-8006 (also referred to as the Daniel Squire Oral D & T Center).
7. Name and address of health care provider/individual person(s) to whom this information will be disclosed.

Name:_____	Name:_____
Address:_____	Address:_____
_____	_____
Phone Number: _____	Phone Number: _____
Fax Number: _____	Fax Number: _____
Relationship:_____	Relationship:_____

8. Specific information to be disclosed:
   ☐ Complete copy of Medical Record OR check all that apply:
   ☐ Discharge summaries ☐ Office notes (except psychotherapy notes) ☐ Radiographic images ☐ Billing records ☐
   Copies of Medical Records for Dates of Service from: (insert date) _____ to _____.
   ☐ Include: (Indicate by Initialing) ____ Mental Health Information ___ HIV-Related Information ___ Drug and Alcohol Treatment Information
9. Reason for release of information:
   ☐ At request of individual ☐ Other: _____
10. This authorization will expire upon:
    ☐ Revocation ☐ One Time Release ☐ Date/Event: _____.

All items on this form have been completed, and my questions about this form have been answered. In addition, I have been provided with a copy of this form.

_____ Date: _____
Signature of patient or representative authorized by law

_____
Name of patient or representative

_____
Relationship to patient (if signing as representative)

UB DENTAL

* Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Important Information

1. **Submitting this form. There are three options:**
   a. **Scan and upload the this completed Authorization to** https://dental.buffalo.edu/patients/current-patients.html
   b. **Fax to (716) 829-2242**
   c. **Mail to Attn: Medical Records, University at Buffalo School of Dental Medicine, 102 Squire Hall, Buffalo, NY 14214-8006**
2. **Obtaining the records. There are 3 options, please initial one:**

   _____ Mail or fax the records to the address listed above in Step 7.

   _____ I will pick up the records. The records will be mailed to the address listed above in Step 7 if you do not pick them up within ten (10) calendar days of the School of Dental Medicine notifying you of their availability. If the records are not picked up within ten (10) days of notification by SDM that your records are ready, the records will be mailed or faxed to the address listed on this authorization form.

   _____ Electronic format (Patient Portal)

Fees for copies of records are as follows:

First copy of radiograph images on CD: No charge
Additional copies of radiograph images on CD: $6.50
Copy of dental records: $6.50

For Office Use Only

Date Request Form Received: _____
Payment Received/Charges Added: _____
Duplicates Made: _____
Picked Up/Mailed/Faxed/Electronic: _____

Version: 8-28-25 kvl
7-10-24 kvl
4-4-24 jh
4-2-24 mp