

**UNIVERSITY OF MINNESOTA | ORAL PATHOLOGY LABORATORY | RELEASE OF RECORDS**

# STEP 1: ENTER PATIENT INFORMATION:

|  |  |
| --- | --- |
| Patient Name (Last, First, and MI): | Date of Birth (MM/DD/YYYY): |
| Phone: | Case #: |

**STEP 2: SELECT DESIRED SERVICE:** Pathology Reports Pathology Slides Other - Please Specify

**STEP 3: ENTER WHERE YOU WOULD LIKE THE INFORMATION SENT:** (Please select one)

**SEND BY US MAIL**

**SEND BY FED EX/UPS(Please provide Label or Acct #)**

Name: Address: Suite/Apt #: City/State:

Zip Code: Phone:

**SEND BY EMAIL (Report Only)**

Name:

E-mail: \_

**PICK UP** (5-7 business days)**:**

(Please Call 612-626-6424 to arrange)

# STEP 4: REASON FOR REQUEST:

**STEP 5: SIGN BELOW: (PATIENT OR LEGAL REPRESENTATIVE SIGNATURE)**

I understand the following:

1. The information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV*/* AIDS, and genetics.
2. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon

this authorization. This authorization may be revoked by providing written notice to: University of Minnesota School of Dentistry, ATTN: Privacy Officer, 8-434 Moos Health Sciences Tower, 515 Delaware Street, S.E., Minneapolis, MN 55455.

1. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by

the federal law.

1. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
2. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
3. This authorization will expire 1 year from the date signed below.
4. All Protected Health Information will be handled in full compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

By signing below, you agree that you understand and accept the terms on this form. You give the University of Minnesota School of Dentistry permission to have your records copied, picked up, mailed or electronically sent to the indicated party above.

**SIGNATURE: DATE:**

**STEP 6: SUBMIT THE SIGNED RELEASE FORM IN ONE OF THESE WAYS:**

|  |  |  |
| --- | --- | --- |
| **MAIL:** | **FAX OR EMAIL:** |  |
| University of Minnesota School of Dentistry  Oral Pathology Laboratory - MMC83  515 Delaware Street S.E. - Room 16-116 Minneapolis, MN 55455 | Fax: 612-626-3076  E-Mail: [oralpath@umn.edu](mailto:oralpath@umn.edu) |  |

**Questions? Please call the Oral Pathology Laboratory Office at (612-626-6424)** Revised 06/28/2017