

**University of Southern Indiana
Dental Clinic**

8600 University Boulevard
Evansville, Indiana 47712

Phone: (812) 464-1706
Fax: (812) 461-5352

RELEASE OF RECORDS

Step 1: PATIENT INFORMATION

First Name	Last Name	Date of Birth	
Street Address	City, State	Zip Code	Phone Number

Step 2: SEND RECORDS TO: (choose ONE delivery option)

☐ SEND BY MAIL OR EMAIL (please circle ONE option)	
Name	Phone Number
Address or Email	City, State, Zip

☐ PICK UP:	
Self or Name of Representative	Phone Number

Step 3: SIGN BELOW: (Patient or Legal Representative) 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 the right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
3. This authorization may be revoked by providing written notice to: University of Southern Indiana Dental Clinic, ATTN: Program Chair, 8600 University Boulevard, Evansville, IN 47712.
4. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
5. The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
6. I acknowledge that it is my responsibility to follow up with the receiving dental office where my records are being sent to confirm receipt of records.
7. This authorization will expire one (1) year from the date signed below.

By signing below, you agree that you understand and accept the terms on this form. You give the University of Southern Indiana Dental Clinic permission to have your records copied, picked up, and mailed physically or electronically to the indicated party above.

SIGNATURE:	DATE:
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