Ohio State Dental Faculty Practice

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize:

Dr. Name: _____

Address: _____

_____

To release the following information for patient name: _____

☐ Treatment Notes ☐ X-Rays

☐ Other (please specify) _____

Please release and furnish information to**: Ohio State Dental Faculty Practice Inc. or Email: DFPRECORDS@OSU.EDU**
305 W. 12th Avenue
2301 Postle Hall Building B
Columbus, OH 43210

Purpose of Disclosure: _____

I understand and acknowledge that this authorization extends to all or any part of the information designated above. This may include treatment/Information for physical and mental illness and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome) and may include results of an HIV test or the that an HIV test was performed. I expressly consent to the release of information designated above. This consent is valid for 60 days from the date signed, unless revoked by my written notice, provided said notice is received prior to release of the above information.

I also acknowledge that there may be fees assessed for the duplication of what is requested above. If the information is being released directly to me, I will be responsible for payment of said fees.

Last 4 digits of Social Security Number: _____

Date of Birth: _____ _____ _____

_____ Date: _____
Signature of Patient or Person Authorized to Consent

_____ Date: _____
Witness

Please fax request back to 614-292-4960

OR

Mail to: Ohio State Dental Faculty Practice Inc., 305 W. 12th Ave., 2301 Postle Hall Building B, Columbus, OH 43210