UCLA School of Dentistry
Dental Clinics

Dear Patient,

Enclosed is an AUTHORIZATION FOR THE RELEASE OF RADIOGRAPHS VIA E-MAIL.

Please complete the form and return it by mail to:

UCLA Dental Clinics
Custodian of Records
10833 Le Conte Ave.
CHS 10-136, School of Dentistry
Los Angeles, CA 90095

You may also fax the completed form to (310) 825-7620.

Please note that only digital radiographs can be e-mailed. Radiographs taken prior to the implementation of digital radiography cannot be e-mailed.

Please also note that most popular email services (ex. Hotmail, Gmail, Yahoo, Outlook) do not utilize encrypted email. When we send your radiographs to you or you send us an email, the information will be transmitted via unencrypted email. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

E-mails regarding your care are considered part of your dental record.

There is a $10 fee for e-mailing digital radiographs. Please make your check payable to **The Regents of the University of California**. You may also make a credit card payment over the phone.

If you have any questions, please call the Custodian of Records at (310) 825-3195.

Yours sincerely,

UCLA Dental Clinics
Custodian of Records

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF RADIOGRAPHS VIA E-MAIL

I, _____, understand the risks of unencrypted email and
[Patient Name]
Authorize the UCLA Dental Clinics to release and disclose my radiographs electronically via unencrypted email to my email address listed below:

_____
E-mail address

_____
Date of Birth

NATURE OF THE INFORMATION TO BE RELEASED

I request and authorize the UCLA Dental Clinics to release and disclose the following patient records (please check all that apply):

- ☐ Full-Mouth Set
- ☐ Bitewings
- ☐ Individual Periapical
- ☐ Panoramic
- ☐ TMJ Views
- ☐ PA Cephalometric
- ☐ Lateral Cephalometric
- ☐ Three-Dimensional Scans
- ☐
Other:_____

TREATMENT PERIOD

I request that the radiographs to be released cover the following time period (please check and enter dates):

- ☐ From _____ to _____
- ☐ All

REVOCATION OF AUTHORIZATION

The UCLA Dental Clinics usually process a request for release and disclosure of patient records within seven (7) business days of receiving this authorization. You may revoke this authorization at any time ***before*** the above request has been processed by sending written notice to:

General Clinic Director
UCLA School of Dentistry
10833 Le Conte Ave.
Box 951668
Los Angeles, CA 90095-1668
jgoldstein@dentistry.ucla.edu

The revocation will take effect upon receipt of your request by the UCLA Dental Clinics, except to the extent that the UCLA Dental Clinics have already relied on the authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization will expire on _____ (*insert applicable date or event*). If no date is indicated, this authorization will expire 12 months after the date of signing this form.

SIGNATURES

_____ _____
Signature of Patient (Area Code) Phone Number

_____ _____
Name of Patient Date

OR

_____ _____
Signature of Patient's Representative Relationship

_____ _____
Name of Patient's Representative Date

If signed by a Patient Representative, please check box in front of reason below.

☐ Patient is a minor.
☐ Patient is legally incompetent to sign.
☐ Patient is unable to read English, but the Patient Screening Notice, Terms, and Consent was translated verbally for the patient, and the patient has given his/her verbal consent.
☐ Patient is physically incapable of signing, but has given his/her verbal consent.