

Release of Protected health information to a designated adult

This form is used to authorize the release of protected health information of a minor child or dependent adult to allow a Grand Dental provider or staff member to discuss treatment and finances with a designated adult. In addition, this form can be used by an adult (age 18 or older) to allow a Grand Dental dental provider or staff member to discuss treatment and finances with a designated adult, including an outside dental or medical practitioner.

This Patient is a: Minor Adult 18 years or older Dependent adult

Patient Name: _____

Address: _____

Phone: _____ Date of birth: _____

I authorize the following persons to receive information about the above named patient concerning dental care, treatment, progress of treatment, and finances during appointments. I specifically authorize disclosure of Protected Health Information (PHI) to the following individual(s):

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

This authorization is valid for the duration of treatment, except as specified: _____

I may cancel this consent at any time by sending a written notice to Grand Dental 1005 Grand Ave. Ste 200 West Des Moines Iowa, 50265. I understand that any discussion of information which was made before I cancelled my consent does not mean that my rights to confidentiality were breached.

Name of patient: _____

Signature of patient, parent, or legal guardian: _____

Date: _____ Relationship to patient: _____

