Release of protected health information to a designated adult

This form is used to authorize the release of protected health information to allow a Grand Dental provider or staff member to discuss your medical history, dental health, dental treatment, appointments, and finances with the individuals designated below. Without this completed form, federal law generally prohibits us from discussing any of your dental findings, needs, or treatment with anyone besides you.

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

Patient Name: _____

Address: _____

Phone: _____ Date of birth: _____

I authorize the following persons or entities to receive information past, present and future concerning my entire dental record including my health history, dental treatment, progress of treatment, and payments, personal information, and finances:

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 Avenue, Suite 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 requester: _____ Relationship to patient: _____

Authorizing signature: _____ Date: _____

GRAND.DENTAL
515-223-1940
ContactUs@Grand.Dental
1005 Grand Avenue, Suite 200
West Des Moines, Iowa 50265