GRAND.DENTAL

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 treatment, appointments, and finances with the individuals designated below. ***Without this completed form, we are unable to discuss 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 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: _____

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