Authorization for Release of Protected Health Information

THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY
& DENTAL CLINICS

With your permission, we may disclose your health information to a family member, friend, or other person to obtain help with your healthcare and payment for your care. This form authorizes the College of Dentistry's dental providers or staff members to discuss your treatment, appointments, and finances with a designated adult as indicated below.

Please PRINT

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

Patient Name: _____
Last First Middle Initial

Address: _____

Telephone: ( ) _____ - _____ Birthdate _____

Last 4 digits of Social Security Number: _____

I authorize the following persons to receive information about the above named patient concerning dental care, treatment, progress of treatment, and finances. I specifically authorize the University of Iowa College of Dentistry & Dental Clinics to disclose my Protected Health Information (PHI) to the following individual(s):

Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient
Name	Phone #	Relationship to Patient

This authorization is valid until otherwise revoked.

I may cancel this consent at any time by sending a written notice to Dental Clinic Administration, W440 Dental Science Building, The University of Iowa College of Dentistry, Iowa City, Iowa 52242-1001. 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 Or of Parent/Legal Guardian**

Date Relationship to Patient