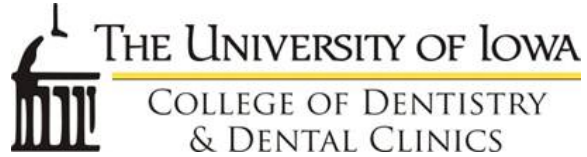


# CONSENT TO RELEASE HEALTH INFORMATION



Please PRINT (except signatures) and provide complete answers (and addresses) in each section.

## SECTION A: PATIENT GIVING AUTHORIZATION

Name: \_\_\_\_\_ Axium #: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Last 4 digits of Social Security #: \_\_\_\_\_

Will the patient be returning to the College of Dentistry for further dental treatment? \_\_\_ Yes \_\_\_ No \_\_\_ Maybe

## SECTION B: INFORMATION REQUESTED

Please be aware that the dental record may contain sensitive material. You have the option of us sending the copy of your record directly to you.

- Radiographs (X-rays)  Pathology Report  
 Progress Notes (Visit Information)

Send to: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Select only one option below'

- Pickup CD  When: \_\_\_\_\_ Where: \_\_\_\_\_  
 Email  Email Address \_\_\_\_\_  
 Mail  Mail Address \_\_\_\_\_  
 Fax (Progress notes only)  Fax Number \_\_\_\_\_

## SECTION C: EXPIRATION and REVOCATION

This authorization will automatically expire one year from the date of signature, except as specified: \_\_\_\_\_ Date

At that time, no express revocation shall be needed to terminate my consent, but understand that I may revoke this consent at any time by sending a written notice to the **Central Records, The University of Iowa College of Dentistry, 203 DSB North, Iowa City, Iowa 52242-1001**. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information by contacting the Central Records, The University of Iowa College of Dentistry, 203 DSB North Iowa City, Iowa 52242-1001.

## SECTION D: PATIENT'S SIGNATURE

I, the undersigned, hereby authorize The University of Iowa College of Dentistry to release dental information concerning the above patient:

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Relationship, if NOT the Patient \_\_\_\_\_

UI College of Dentistry

Central Records  
dent-crec@uiowa.edu

203 Dental Science North  
Iowa City, Iowa 52242-1001

319/335-7429  
Fax 319-335-7417