Ed Dye Family Dentistry P.C.

Authorization for Release of Protected Health Information (PHI)

With your written permission, we may discuss your health information with a person(s) you designate. Your authorization allows dental providers and staff members at the Ed Dye Family Dentistry P.C. to discuss your health history, dental treatment, finances and appointments (including scheduling) with a designated adult such as a family member, friend, dental or medical practitioner outside the College. Please **consider** listing your emergency contact.

PLEASE PRINT

Patient name:_____

First name Middle initial Last name

This patient is an: ☐ Adult (18 years or older) ☐ Minor child ☐ Dependent adult

_____

Address City State Zip

Telephone: ( ) _____-_____ Birthdate:_____/_____/_____

month day year

☐ **No, I do NOT want my Protected Health Information shared with any individuals.**

☐ **Yes, I specifically authorize Ed Dye Family Dentistry P.C. to disclose my Protected Health Information (PHI) to the following individual(s):**

1._____

Name Phone # Relationship to patient

2._____

Name Phone # Relationship to patient

3._____

Name Phone # Relationship to patient

4._____

Name Phone # Relationship to patient

5._____

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 Ed Dye Family Dentistry P.C.,3250 10th Ave Suite 2 Marion, Iowa 52302. 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 parent/legal guardian**

_____

Date **Relationship to patient**