Authorization for Release of Protected Health Information (PHI)

THE UNIVERSITY OF IOWA
COLLEGE OF DENTISTRY & DENTAL CLINICS

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 University of Iowa College of Dentistry and Dental Clinics 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

☐ **Yes, I specifically authorize the University of Iowa College of Dentistry & Dental Clinics 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

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

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 parent/legal guardian**

Date **Relationship to patient**