Consent to Release Health Information

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

Dr. Karl Eischeid
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To ensure that this request is processed in a timely manner, make sure all information is complete.
This release is not valid if it does not contain the patient's signature and date signed.
A copy of this form will be provided at the patient's request.

Section A: Patient Giving Authorization

Name: _____

Address: _____

Telephone: _____ Email: _____

Date of Birth: _____ Social Security #: _____ Chart#: _____

Section B: Information Requested

Please specify the type of information requested. Please be aware that the dental record may contain sensitive material including: Substance Abuse (Alcohol/drug Abuse), Mental Health, HIV-Related Information (AIDS related testing).

Information to be released:
_____Medical Information
_____ X-Ray films
_____Medications
_____Other

Dates of Treatment
From: all current records To: Present Date
All Current X-Rays and panoramic films

_____

I authorize Carroll Dental Associates, either orally or in writing, to release to or obtain from:

Name/Agency _____

Address _____

_____

Phone _____

the following specificied information from my records for date(s) of service from _____ to _____.

Section C: Expiration and Revocation

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

I understand that I may revoke this consent at any time by sending a written notice. 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.

Section D: Patient's Signature

I, the undersigned, hereby authorize release of dental information concerning the above patient:

_____
Signature of Patient or Legal Guardian Date

_____
Address City State Zip

_____
Relationship, if NOT the Patient