Waukee Dental
Kaisha Brown, DDS
350 East Hickman Road
Waukee, Iowa 50263

# Release of Protected Health Information to a designated adult

The form is used to authorize health information to a designated adult. This form is used to authorize the release of protected health information of a minor child or dependent adult to allow a Waukee Dental provider or staff member to discuss treatment and finances with a designated adult. In addition, this form can be used by an adult (age 18 or older) to allow a Waukee Dental provider or staff member to discuss treatment and finances with a designated adult, including an outside dental or medical practitioner.

This Patient is a: ☐ Minor ☐ Adult (age 18 or older) ☐ Dependent adult

Patient Name: _____

Address: _____

Phone Number: _____ Date of Birth: _____

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I authorize the following persons to receive information about the above named patient concerning dental care, treatment, progress of treatment and finances during appointments. I specifically authorize disclosure of Protect Health Information (PHI) to the following individual(s):

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

This authorization is valid for the duration of treatment, except as specified:

_____

I may cancel this consent at any time by sending a written notice to:

Waukee Dental
350 East Hickman Road
Waukee, Iowa 50263

***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, parent or legal guardian: _____

Date: _____ Relationship to patient: _____