CHI St. Joseph Children's Health

Authorization to Release Patient Information

Date: ___/____/_____

Patient Name: _____ Date of Birth: ___/___ / _____

I, _____, hereby authorize **CHI St. Joseph Children's Health** to release the following information from my dental records and/or I request that CHI St. Joseph Children's Health complete the following forms on my behalf which include patient information from my dental record:

☐ My complete dental record.
☐Include health information related to drug and alcohol abuse ☐Include health information related to HIV/AIDS

☐ Dental records up to the past ___ years (Maximum of 5 years).

☐ The date and treatment plan from my most recent dental exam.

☐ My dental information relating to the following treatment or condition:
_____

☐ The information necessary for completion of the required dental exam reporting form from my child's school district.

The information requested is to be used for the following purpose:

☐ Fulfill a School Requirement

☐ Transfer care to another provider

☐ Completion of specialty services including but not limited to oral surgery

This Authorization permits CHI St. Joseph Children's Health to release the above requested information to the following Person or organization:

_____
_____
_____
_____

Authorization and Signature: I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.
I understand that I may revoke this consent at any time by notifying CHI St. Joseph Children's Health in writing, and/or specifying revocation. This consent will automatically expire ninety (90) days. I have read this form or have had it explained to me and I understand its contents.

Signature_____ Date:_____

Relationship to the Patient: _____

Witness:_____ Date:_____

Please initial one option below:

_____ I have accepted a copy of this form _____I have declined a copy of this form