



# Rand Center for Dentistry

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## Consent to Share Confidential Medical and Dental Information

*This form is valid only if it is filled out COMPLETELY, including specifying the information you are giving us permission to share.*

Patient's Legal Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

### **I HEREBY AUTHORIZE RAND DENTAL TO SHARE THE FOLLOWING MEDICAL OR DENTAL INFORMATION:**

- Any information that may be relevant to my continued health and treatment, additionally including:
  - My dental status and history, and any treatments I am receiving
  - My drug and alcohol history
  - Any diseases or conditions I have been diagnosed with, and their treatment
  - My pregnancy status, birth control, and related information
- My appointment times, dates, and the general reasons for the visits
- The assessments and recommendations made by one of our doctors or professionals
- The results of any tests performed
- Medications I am taking or have been prescribed
- Additional (please specify): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **I HEREBY AUTHORIZE THIS INFORMATION TO BE SHARED WITH THE FOLLOWING PEOPLE, ADDITIONALLY ALLOWING CONTACT THROUGH:**

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_  Email: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_  Email: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_  Email: \_\_\_\_\_

I understand that I may cancel this consent at any time by written request to Rand Dental Associates, P.A., but I also understand that cancelling it will not affect any information that has already been released.

I understand that it is not required that I sign this form, and that I will only sign it if I wish for Rand Dental to share my information with someone I have designated on this form.

This authorization will automatically expire, if I do not cancel it in writing first, upon the following event or date: \_\_\_\_\_

If no expiration date or event is specified, then this authorization will expire one (1) year after the date this form is signed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to minor patient (if parent or legal guardian): \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_