Rand Center for Dentistry

Elliot J. Rand, D.D.S.
General, Laser & Cosmetic Dentistry • Lic. #D1 16358

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.

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.

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.

❒ I DECLINE to sign this agreement. I do not want to authorize anyone to share my information with.

Signature: _____ Date: _____

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

Witness: _____ Date: _____