Dr. Jackie Smith & Dr. Jeff Stewart
Ankeny Dental Center, PC
306 SW Walnut St.
Ankeny, IA 50023
Phone: (515) 964-0621
Fax: (515) 964-2408

CONSENT TO SHARE CONFIDENTIAL MEDICAL/DENTAL INFORMATION

TO BE VALID, THIS FORM MUST BE FILLED OUT COMPLETELY, INCLUDING WHAT INFORMATION YOU ARE GIVING US PERMISSION TO SHARE.

PATIENT'S LEGAL NAME: _____

DATE OF BIRTH: _____

I HEREBY AUTHORIZE ANKENY DENTAL CENTER TO SHARE:

___ ANY OF MY MEDICAL/DENTAL INFORMATION

___ MY APPOINTMENT TIMES, DATES, AND REASONS FOR MY VISITS

___ MEDICATIONS I AM TAKING

___ THE FOLLOWING INFORMATION (SPECIFY) _____

WITH THE FOLLOWING PEOPLE:

FULL NAME: _____ RELATIONSHIP:_____

FULL NAME: _____ RELATIONSHIP:_____

FULL NAME: _____ RELATIONSHIP:_____

FULL NAME: _____ RELATIONSHIP:_____

I UNDERSTAND THAT I MAY CANCEL THIS CONSENT AT ANY TIME, BUT CANCELLING IT WILL NOT AFFECT ANY INFORMATION THAT HAS ALREADY BEEN RELEASED.

I UNDERSTAND I DO NOT HAVE TO SIGN THIS FORM, AND THAT I SHOULD ONLY SIGN IT IF I WANT MY DENTAL PROVIDER OR ANKENY DENTAL CENTER TO SHARE MY INFORMATION WITH SOMEONE.

THIS AUTHORIZATION EXPIRES:

____ WHEN I CANCEL IT IN WRITING

____ (EVENT) _____

IF NO EXPIRATION DATE OR EVENT IS SPECIFIED, THIS AUTHORIZATION WILL EXPIRE IN 1 YEAR AFTER THE DATE IS SIGNED.

SIGNATURE OF PATIENT (OR PARENT OR LEGAL GUARDIAN IF UNDER THE AGE OF 18):

_____

DATE:_____