James D. Rohan, DDS, P.C.
Kevin D. Dow DDS
30 N. Michigan Avenue
Suite 1506
Chicago, IL 60602
312-372-4845

HIPAA-Authorization and Consent to Release and Review Medical/Dental Information and Records

Patient Name _____

I understand that all patients have the right to expect that all communications and records pertaining to their case should be treated as confidential. I understand that I may receive a copy of the Notice of Privacy Practices if I wish.

So that Dr. Rohan and Dr. Dow may make a thorough examination and diagnosis, I also understand that the Doctors may need to obtain information from my medical doctor(s) and/or prior dentists(s). Therefore, I grant you the right to obtain information about my health condition from my medical doctors and other dentists. Such records will then be considered by me to be a part of Dr. Rohan's and Dr. Dow's records.

I also give Dr. Rohan and Dr. Dow permission to share my health information with other health care professionals and dental specialists who would include the release of my dental charts and records for the sole purpose of consultation regarding diagnosis, treatment planning and care.

I also give permission to an authorized insurance company to review my records for the purpose of payment for treatment. I will not hold Dr. Rohan or Dr. Dow responsible in the rare event that records, or x-rays, or copies are lost by an insurance company.

I understand that I may revoke this authorization, at any time in writing.

X_____

Signature of Patient, Parent or Guardian Date