

Residency Authorization

Idaho State University Family Dentistry is the treatment clinic for the Idaho Advanced General Dentistry (IAGD) Residency Program. The Program is directly associated with and directed by Idaho State University as a Program providing an advanced general dental education to select graduate dentists.

Because of the nature of the educational requirements of the IAGD, certain patient health and previous dental history, diagnostic aids, treatment and care provided by the Resident Doctors are documented in the form of photographs, x-rays, casts, and printed material either as hard copies or electronically stored on computerized disks.

These materials are used by the Resident Doctor to demonstrate progress and abilities learned and applied in the IAGD Program. The documents are solely to be used for the professional advancement of the Resident Doctor.

The health information included in these documents may be used for scientific presentations to other health professionals. There will be no notation or identification of the patient by name, address, phone, or fax numbers or e-mail address. There will be no identification of the patient by any identification number issued by either local, state, or federal entities or any other private company.

Unsecure Email Communication: This information can be used to complete consultations with healthcare professional in association with your treatment. These consultations will be conducted through an email source that is not encrypted and therefore not secure. As a result your electronic personal health information could be viewed by others who are not the intended recipient.

Photographs: Pictures may at times include full frontal facial images and right and left full profile images. No names will be evident on any photograph.

Written history and treatment records: Written documents pertaining to the diagnosis, treatment plan, and progress notes may be present but no name or identifier will be present.

X-Rays: Radiographs may be duplicated and presented but no reference will be made as to the identification of the patient.

Casts and study models: No identifying marks or label will be present on any casts or duplicates of casts.

Consent

I hereby give my consent and authorization for the use of my health history, dental history, treatment plan, progress notes, x-rays, photographs, study casts and other materials related to dental treatment received at the Idaho State University Family Dentistry for the purposes of evaluation and demonstrating the professional accomplishments of the Resident Doctors of the IAGD Program, provided that I am not identified by name or number. This authorization extends until revoked in writing.

Signed By: _____

Parent/Guardian or Responsible Party

Date: _____