Authorization to Release Health Care Information

Patient's name: ____________________________________ DOB: ___________

Previous Name: ____________________________________

Reason for Records Request: ____

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We appreciate all comments and/or suggestions for improvement that you may have for us.

I request and authorize Dimples Family Dentistry to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: _____________________________ State: _____ Zip: ____________

Phone: ___________________________ E-mail: ___________________________

This request and authorization applies to (please check one of the following):

□ Current X-rays □ Treatment Record including Periodontal Charting (if available)

□ Other: ____

I understand that my express consent is required to release any healthcare information.

I am aware that there is some level of risk that 3rd parties might be able to read unencrypted emails.

____ ______________________

Signature of patient, parent or court appointed legal guardian Date

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Relationship or status if signed by anyone other than patient (i.e., parent, court appointed legal guardian)

Email: reception@dimplesdentist.com

Fax completed form to: 360-887-2309