

Authorization to Release Health Care Information

Patient's name: _____ DOB: _____

SSN: _____ Previous Name: _____

I request and authorize

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

to release health care information of the patient name above to:

Name: Wendel Family Dental Centre

Address: 7012 NE 40th Street

City: Vancouver State: WA Zip: 98661

Phone: 360-254-5254 Fax: 360-254-3698

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition, or dates of treatment: _____
- All healthcare information
- Other: _____

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and treatment.

Signature of patient or patient's authorized representative

Date

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)