Authorization to Release Health Care Information

(There is a minimum $30 charge to duplicate records not sent directly to another dental office.)

Patient's name: _____ DOB: _____

Previous Name: _____

Reason for Records Request: _____

_____

_____

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

I request and authorize Wendel Family Dental Centre 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

_____

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

Fax completed form to: 360-944-3835