Authorization to Release Health Care Information

Patient's name: _____ DOB: _____
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: 360-944-3835
Email: xray@wendeldental.com

This request and authorization applies to:

□ Current x-rays and periodontal charting
□ Other: _____

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

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