AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name_____ Date of Birth_____

SS#_____ Previous Name_____

I request and authorize_____to release health care information of the patient named above to:

Jonathan J. Smith, DDS
315 W Hastings Road
Spokane, WA 99218
Phone: (509)466-2373
FAX: (509)466-4707
E-mail: smithfamilydental@comcast.net

□ Health care information relating to the following treatment, condition, or dates of treatment

_____

□ All health care information

□ Other: _____

I understand that my express consent is required to release my health care information relating to testing, diagnosis and/or treatment. If I have been tested, diagnosed, or treated for any disorder you are authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____

Signature of patient or patient's authorized representative Date signed

_____

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

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

Confidentiality Notice

This facsimile transmission is intended only for the addressee named above. It contains information that is privileged, confidential, or otherwise protected from use and disclosure. If you are not the intended recipient, you are hereby notified that any review, disclosure, copying, or dissemination of the transmission, or the taking of any action in reliance on its contents, or other use is strictly prohibited. If you have received this transimission in error, please notify us by telephone so that we can arrange for its return.
Thank you for your cooperation.