GATEWAY DENTAL

Authorization to Release Health Care Information

Patient name: _____ Date of birth: _____

I request and authorize Gateway Dental Centre to release dental health care information about the above named patient to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Affiliation to Patient: _____

This request is an authorization to release (select one):

☐ All dental health care information relating to treatment, condition, or dates of treatment (describe below).

☐ Copies of all dental health care information, radiographs, and all dental chart components. I understand that there is a fee associated with the duplication of these records. I understand that I am entitled to copies of documents and radiographs and that the original documents and radiographs remain the property of Gateway Dental Centre pursuant to RCWW 70.02.

☐ Other (describe below).

I understand that my expressed consent is required to release any health care information relating testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug/alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug/alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Patient/Guardian signature: _____ Date: _____

NOTE: Pursuant to the Health Insurance Portability and Accountability Act of 1996, this is a proprietary document that contains protected health information. This document may not be viewed by persons for whom this information, appearing herein, is not legitimate job related information, associated with the rendering of health treatment or appropriate administrative support to the patient.

GATEWAY DENTAL
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