Authorization to Release Health Care Information

Patient name: ______________________ Date of birth: ____________

I request and authorize ______________________________
(name of dental practice)

to release dental health care information about the above named patient to Gateway Dental Centre.

This request is an authorization to release:

Copies of all dental health care information, radiographs, and all dental chart components.

All dental health care information relating to the treatment, condition, or dates of treatment described below (see below for detail).

Other (described below).

Please send records to:

Gateway Dental Centre
999 Third Ave, Plaza 18, Seattle, WA 98104
Phone: (206) 343-8929 / Fax: (206) 343-9934
Email: team@gateway.dental

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.