Authorization to Release Health Care Information

Patient name: _____ Date of birth: _____

I request and authorize Reflections 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 Reflections 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: _____

REFLECTIONS DENTAL CENTRE
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