AUTHORIZATION FOR DISCLOSURE

AND

RELEASE OF DENTAL INFORMATION

TO: Family Dental Associates

RE: ______________________________
(print: *patient name)*

You are hereby authorized and directed to send any and all information regarding my dental records, including copies of medical history, x-rays, business records, progress notes and reports received from any other person with reference to my treatment, to the following:

_____ I choose to have these records emailed unencrypted.

_____ I choose to have these records emailed encrypted.

Email address: __________________________________

I understand that my records may contain information regarding the diagnosis or treatment of any and all medical conditions as provided during medical history updates. I understand that this may take 14 days once the office receives this completed form to duplicate the records. According to Washington state law, there will be a fee for this service. You have my specific authorization for theses records to be released.
Mail:

____
(Dentist's name)

____
(Address)

____
(City, State, Zip)

SIGNATURE _____________________________ DATE_________________