Authorization to Release Information

Patient Name:

Patient Date of Birth:

Previous dental office name:______________________________

Phone number:____

"I here by authorize this practice to make use and disclosure of my protected health information as indicated below."

This information is to be disclosed to:

Renton Dental Arts
17816 108th Avenue SE
Renton, WA. 98055

If digital, please e-mail to: info@rentondentalarts.com

Description of information to be disclosed:

Reason for requested use or disclosure:

To be read and signed by patient

a) I may revoke this authorization at any time by providing written notice to the practice.
b) I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
c) No one has pressured me to sign this authorization.
d) I acknowledge I have had an opportunity to review this authorization and the intent and use.

Patient Signature or signature of Patient's Representative:____________________________

Relationship: _________________________ Date: ____________________________

P 425-228-3420 F 425-228-3773
17816 108th Ave SE Renton, WA 98055
info@rentondentalarts.com