AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Name: _____

Date of Birth: _____ Medical Record Number: _____

Address: _____

I, _____, hereby authorize the use or disclosure of the above individual's health information as described below:

RECORDS **REQUESTED BY** EASTSIDE PEDIATRIC DENTAL GROUP:

Please mail records to: 185 NE Gilman Blvd, Issaquah, WA 98027 or fax records to: (425)557–1138. For electronic records, please email to: office@eastsidepediatricdental.com

Records requested for services provided _____/_____ through _____/_____.

Medical Clinic Notes Dental Clinic Notes Discharge Summary

Operation Dictation Report(s) from Dentistry and/or Oral and Maxillofacial Surgery

Dental X-rays taken within the last _____ months/years from date of request

_____

RECORDS **REQUESTED FROM** EASTSIDE PEDIATRIC DENTAL GROUP TO:

Name of person/office to receive records: _____

mailing address: _____

email: _____

phone: _____ **fax:** _____

Records requested for services provided _____/_____ through _____/_____.

Transfer form with treatment and hygiene summaries Progress Notes

Dental X-rays taken within the last ____ months/years from date of request

_____

PURPOSE OF RELEASE: Personal Records Transfer to a New Provider

_____ Continuation of Care

I understand that:

- the information in this health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services or treatment for alcohol or drug abuse.
- authorization of this health disclosure is voluntary. I have the right to refuse to sign this authorization.
- I have the right to cancel this authorization at any time by writing to Eastside Pediatric Dental Group. Cancellation will not apply to: information already released in response to the authorization and my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules.
- I need not sign this form in order to assure treatment.
- I may inspect or obtain copies of the information to be used or disclosed.
- unless, otherwise cancelled, this authorization will be good for one year from date of signature.

_____ _____ _____

Signature of Patient or Legal Representative Relationship to Patient Date