

Gateway Dental Centre
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Seattle, WA 98104-5000
(206) 343-8929 FAX (206) 343-9934

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

I request and authorize Gateway Dental Centre to release dental health care information about the above named patient to:

Name: _____

Address: _____

City, State, Zip Code: _____

Affiliation to Patient: _____

This request and authorization applies to:

_____ All dental health care information relating to the following treatment, condition or dates of treatment:

_____ 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 Gateway Dental Centre pursuant to RCW 70.02.

_____ Other: _____

I understand that my expressed consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or 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 Signature: _____ Date: _____

Signature of Guardian if Applicable: _____

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 WHICH THE INFORMATION APPEARING HEREIN IS NOT LEGITIMATE JOB RELATED INFORMATION ASSOCIATED WITH RENDERING HEALTH TREATMENT OR APPROPRIATE ADMINISTRATIVE SUPPORT TO THE PATIENT. A:/HIPAA RELEASE 03/04/2003 8:28:13 AM