Authorization to Release Health Care Information

Patient's Name_____ Date of Birth _____

Additional Family Members

_____

I request and authorize _____to release health care information of the patient name above to:

Lupita Fernandez, DMD, PS

1711 East Division Street

Mount Vernon, WA 98274

P: (360) 424-7089

Info@fernandezdental.com

This request applies to:

___ Health care information relating to the following treatment, conditions or dates of treatment:

_____

___ FMX/Pano taken within the last 5 years **AND** BWX taken within the last 12 months

___ Perio Charting

___ All health care information

___ Other:_____

I understand that the specific type of information disclosed may include a details report of examinations, treatment provided, x-rays and other records related to my dental information.

Signature of Patient/Authorized Representative _____

Relationship _____

Date _____