Authorization to Release Health Care Information

Patient's Name____

Date of Birth_______________________ SSN______________________________

I request and authorize the office of Jenny Lee D.D.S., Cody Mast D.M.D at 34929 S.E. Ridge St. #220, Snoqualmie, Wa. 98065 to release my health care information for the patient/patients named above to:

Name____

Address____

City, State_________________________________ ZipCode____________________

This request and authorization applies to:

_______ Health care information relating to the following treatment, condition, or dates of treatment ____

_____ All health care information

_____ Other____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV(AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and /or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Note: There could be a minimum $15.00 records copying fee per patient. When the copy fee and this signed release are received, your records will be transferred to the above Dentist.

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Signature of patient or patient's authorized representative Date signed

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Relationship or status if signed by anyone other than patient

____

Jenny Lee D.D.S., Cody Mast D.M.D.
34929 S.E. Ridge St. #220, Snoqualmie WA. 98065
425-396-1011Ph
425-396-1258 Fax