AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

PREVIOUS NAME:_____

I request and authorize _____ to release health care information for the patient named above to:

LINCOLN HEIGHTS DENTAL CENTER
DR. DAVE COYNER
2656 EAST 29TH AVE.
SPOKANE, WA 99223
Phone #509-535-7791
Fax #509-535-1833
LINCOLN2@ZTC.NET

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, 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 and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED