OLYMPIA PEDIATRIC DENTISTRY

Andrea M. VanCleave, DDS, MSD

Phone: 360-352-3515

2612 Yelm Highway SE, Suite A, Olympia, WA 98501

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's name: _____ Date of birth: _____

I request and authorize Olympia Pediatric Dentistry to release health care information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip Code: _____

E-mail: _____

_____ Release x-ray records

Reason for transfer of records:

_____

_____

Signature of patient or patient's authorized representative Date

_____

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