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# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

☐ I request and authorize Harmony Family Dentistry to release health care information of the patient named below to:

To:_____________________________________________
Phone #:_________________________________________
Fax #:___________________________________________
Email:___________________________________________

☐ I request and authorize the release of all dental radiographs and information for the patient below to be sent to:

**Harmony Family Dentistry**
1900 NE 162nd Ave, Suite D101
Vancouver, WA 98684
office@HarmonyFamilyDentistry.com

THIS REQUEST APPLIES TO:

☐ Dental information relating to the following treatment, condition or specific dates of treatment:______________________________________________________________
☐ Current Dental Radiographs
☐ Other: ________________________________________________________________

PATIENT NAME:________________________________ DATE OF BIRTH:_____________

PATIENT NAME:________________________________ DATE OF BIRTH:_____________

I understand that my consent is required to release any healthcare information relating to testing, diagnosis and treatment.

___________________________________ ______________________
Signature (Patient, Parent or Guardian) Date