AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

PATIENT NAME _____

PREVIOUS NAME _____

I request and authorize:

DENTIST _____

ADDRESS _____

To release dental care information of the patient(s) named above to:

MACFARLANE, BELL & THOMPSON
525 HIGH SCHOOL ROAD NW
BAINBRIDGE ISLAND, WA 98110
(206) 842-4794

This request and authorization applies to:

_____ All health care information in my dental records
_____ Health care information relating to a specific treatment or condition
_____ Other: (e.g., x-rays, charting)

I understand that my consent is required to release any dental 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. I understand I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to take part in a research study or receive health care when the purpose is to create health care information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Bell Thompson; PLLC based upon this authorization by filling out a revocation form available from Bell Thompson, PLLC or write a letter to Bell Thompson, PLLC. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____
Signature of patient or patient's authorized representative

_____
Relationship to patient Date