HARMONY
FAMILY DENTISTRY

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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