AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name:_____Date of Birth_____

SS#_____Previous Name:_____

I request and authorize _____to release health care information of the patient named above to:

Dr. Peter Milgrom
Dental Fears Research Clinic
University of Washington
Box 357475
Seattle, WA 98195-7475

This request and authorization applies to:

_____Health care information to the following treatment, condition , or dates of treatment:
_____(Dental Treatment & Charting)

_____All Health care information

_____Other **(X-Rays)_____**

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus,) sexually transmitted diseases, psychiatric disorders/mental or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental 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

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED