Authorization to Release Health Care Information

Patient's name:________________________________ Date of Birth: _______________

SSN: __________________________ Previous name: _____________________________

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

David T. Chuljian, DDS
1303 Washington Street
Port Townsend, WA 98368
(360) 385-3100

This request and authorization applies to:

_________ Health care information relating to the following treatment, condition, or date of treatment:

____

_________ BW X-rays within the past two years, FM X-rays within the past five years, and perio probings dating within the last two years

_________ Other: ____

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 health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, 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

____

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

Use the above page if you are getting your X-rays sent to us

Use page below to have us send your X-rays to another office

Authorization to Release Health Care Information

Patient's name:________________________________ Date of Birth: _______________

SSN: __________________________ Previous name: _____________________________

I request and authorize: David T. Chuljian, 1303 Washington Street, Port Townsend, WA 98368 (360) 385-3100 to release health care information of the patient above to:

Name ____________________________________
Address __________________________________
City, State, Zip _____________________________
Phone (_____) _________________

This request and authorization applies to:

_________ Health care information relating to the following treatment, condition, or date of treatment:

____

_________ BW X-rays within the past two years, FM X-rays within the past five years, and perio probings dating within the last two years

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