FERNWOOD
FAMILY DENTAL
DR. FUGERE AND DR. LECLAIR

AUTHORIZATION TO RELEASE HEALTH/DENTAL CARE INFORMATION

Patient Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize (Name of previous dentist) _____

OR (Name of Medical Doctor) _____

Address: _____

Phone # _____ to release health/dental care information of the patient named above to:

Fernwood Family Dental

19500 10th Ave. NE, Suite #210

Poulsbo, WA 98370

Phone: (360)394-4337 Fax: (360)394-4334 Email: info@fernwoodfamilydental.com

This request and authorization applies to:

_____ Health care information relating to the following treatment, condition or dates of treatment:
_____

_____ All health/dental care information

_____ Other: _____

I understand that my express consent is required to release any health/dental care information relation to resting, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drugs and/or alcohol use. If I have been tested, diagnosed, or treated for HIV/AIDS, 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 diagnosing, testing, or treatment.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by anyone other than the patient