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 named above to:

Name: Kirk E. King, DDS, PS Phone: 425-226-4090

Address: 66 Williams Ave S

City, State: Renton WA Zip Code: 98057

email drking@dare2smile.com

This request and authorization applies to:

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

_____ All health care information.

_____ 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 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.)

REASON FOR LEAVING:_____

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED