RECORDS REQUEST

AUTHORIZATION FOR RECORDS RELEASE

I, _____, hereby authorize the office of _____ to release the following Protected Health Information:

FMX within the last 5 years, BWX within the last 2 years and a dental treatment history.

The indicated items should be mailed or emailed to info@daytondentalsmiles.com

Paper copies can be mailed to:

Dayton Dental
555 Dayton Street, Suite B
Edmonds, WA 98020

DURATION OF AUTHORIZATION

This authorization shall be in force and effect for:

☐ Thirty days from the signed date.
☐ The date of _____

I understand that I have the right to revoke this authorization at any time by sending written notification.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that records will be available during office hours no sooner than three working days form receiving this request and that under Washington state law I may be required to pay for researching and copying prior any material being released to me.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative