Dayton Dental

Authorization of Records Release

I, _____, hereby authorize the office of Matt Flugstad, D.D.S. to release the following Protected Health Information:

- ☐ X-Rays Only
- ☐ Records from _____ to _____
- ☐ X-Rays and Dental History

To the office of: _____ _____, _____
City State

Office Phone Number: _____ Email: _____

Please share the reason you are transferring offices: _____

_____

I understand that I have the right to revoke this authorization at any time by sending written notification to Dr. Flugstad or his associates. I understand that any revocation is not effective to the extent that Dr. Flugstad or his associates have relied on the use or disclosure of the protected health information.

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.

This authorization will expire 30 days from the signed date. Please allow 3 business days to process your request.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

555 Dayton Street, Suite B
Edmonds, WA 98020
www.daytondentalsmiles.com
info@daytondentalsmiles.com