GO family dentistry at the Landing

1002 park avenue north, suite k | renton, wa 98057 | 425.226.1990 | www.gofamilydentistry.com

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ D.O.B. _____

Previous Name: _____

I request and authorize _____ to release dental health care information about the

( name of the dental practice)

above named patient to Go Family Dentistry.

This request and authorization applies to:

- ◎ Copies of all dental health care information, X-rays, and all dental chart components.
- ◎ All dental health care information relating to the treatment, condition, or dates of treatment described below (see below for detail).

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Please send records to:

Go Family Dentistry
1002 Park Ave N, Suite K
Renton, WA 98057
Phone: 425-226-1990 Fax: 425-228-6806
Email: info@gofamilydentistry.com

Patient Signature: _____ Date signed: _____

Parent or Guardian Signature if under 18: _____ Date signed: _____