VIEWPOINT
DENTISTRY

Authorization to Release Health Care Information

Patient's name: _____ Date of birth:_____

SSN:_____ Previous name (if applicable):_____

I request and authorize_____ to release health care information of the patient named above to:

Dennis L. Higgins, D.D.S., P.S.
90 Columbia Point Drive
Richland, WA 99352
509-946-9313
viewpointdentistry@gmail.com

This request and authorization applies to:

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

_____ All health care information.

_____ Other: Dental X-Rays (pano or fmx within 5yrs & bwx within 2yrs) and Perio Charting

_____

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.)

THIS AUTHORIZATION EXPIRES 90DAYS AFTER THE DATE IT IS SIGNED

Please send to your previous Dentist for current records