Authorization to Release Health Care Information

Patient's Name_____

Date of Birth_____ SSN_____

I request and authorize the office of Jenny Lee D.D.S., Cody Mast D.M.D at 2150 112th Ave. N.E. #A in Bellevue, WA. 98004 to release my health care information for the patient/patients named above to:

Name_____

Address_____

City, State_____ ZipCode_____

This request and authorization applies to:

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

_____ All health care information

_____ Other_____

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, you are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Note: There could be a minimum $15.00 records copying fee per patient. When the copy fee and this signed release are received, your records will be transferred to the above Dentist.

_____

Signature of patient or patient's authorized representative Date signed

_____

Relationship or status if signed by anyone other than patient

_____

Jenny Lee D.D.S., Cody Mast D.M.D.
2150 112th Ave. N.E. #A Bellevue, WA. 98004
(425)455-0784 Ph
(425)451-3999fax