LAKE UNION FAMILY DENTAL

GEOFFREY SEUK, DDS, PS

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____ Date of Bith: _____

Previous Name: _____

My Authorization:

I request and authorize Dr. _____

to release health care information to:

Name: _____

Address: _____

City, State: _____ Zip: _____

This request and authorization applies to:

( ) All health care information in my medical/dental record

( ) Health care information relating to the following treatment or condition:

_____

( ) Health care information for the following date(s): _____

( ) Other (e.g. x-rays, bills) specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

( ) HIV (AIDS Virus)

( ) Sexually transmitted diseases

( ) Psychiatric disorders/mental health

( ) Drug and/or alcohol abuse

This authorization ends:

( ) At my request

( ) When the following event occurs: _____

( ) In 90 days from the date signed

Patient's/authorized representative signature:_____

Date: _____

Relationship or status of authorized representative signatory: _____