Authorization to Release Health Care Information

Patient(s) Name(s):_____

Date(s) of Birth: _____

I request and authorize Doctor Stephen Beck to release all health care information of the patient(s) named above to:

Name: _____

Email address: _____

Address: _____

City, State, Zip: _____

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. If I have been tested, diagnosed, or treated 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.

I understand that my health care information and/or x-rays may be transmitted electronically and I agree to such transmission.

Signature of patient/parent **Date**

mail to Fircrest Childrens Dentistry: 1501 Regents Blvd. #200, Fircrest, WA 98466

or Fax to: 253-295-3600