8019 Aurora Ave N, Seattle WA 98103
Ph. 206.784.9525 Fax.206789.5607

Authorization For Release of Information

Section A **Must be completed for all authorization**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient name: ____ ID Number:______________________________

Persons/Organizations providing the information:	Persons/Organizations receiving the information:
	GREEN LAKE DENTISTRY **8019 Aurora Ave N** **Seattle WA 98103**

Specific description of information (including date(s):____

____

Section B **Must be completed only if a health plan or a health care provider has requested the authorization:**

1. What is the purpose of the use or disclosure?____

____

2. Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes_________ No________

3. The patient or the patient's representative must read and initial the following statements:

a) I understand that my health care and the payment for my health care will not be affected if I do not sign this form.
Initials: _________________

b) I understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. Initials: __________________

Section C **Must be completed for all authorizations:**

Authorization Term	Initials
This authorization will expire on ______ /______ /______ DD MM YY	
I understand that I may revoke this authorization at any time by notifying Green Lake Dentistry in writing, but it won't have any affect on any actions they took before they received the revocation.	

(Form must be completed before signing.)

____ ______________________________________

Signature of Patient or Patient's Representative Date

____ ______________________________________

Printed name of patient's representative: Relationship