Authorization To Release Health Care Information

Patient(s) name(s)/Date(s) of birth: ______________________________

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I request and authorize Dr.________________________________ to release health care information of the patient(s) named above to:

PEARL CARE DENTAL

Michael R. Cole, DDS, PS

PO BOX 1210

ELLENSBURG, WA 98926

Phone: 509-925-6553 Fax: 509-962-6712

This request and authorization applies to all healthcare information and copies of radiographs.

Other: ____

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I understand that my express consent is required to release any health care information. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

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Signature of patient or patient's authorized representative Date

____

Relationship or status if signed by anyone other than patient

FAX TO: ____

Rev. 4/2008