Ellensburg Dental Care
1206 N. Dolarway, #101
Ellensburg, WA 98926
Ph: (509) 933-2400 Fax: (509) 933-4804

Dentist_____ Acct#_____

AUTHORIZATION FOR ELLENSBURG DENTAL CARE TO USE OR DISCLOSE MY DENTAL INFORMATION

Patient Name _____ Date of Birth_____ Phone#_____
Last First MI

I hereby authorize and request you to release a copy of dental records	
TO: (Please provide complete address)	FROM: (Please provide complete address)
Dr/Name/Office Ellensburg Dental Care	Dr/Name/Office_____
Address 521 E Mountain View Ave	Address_____
City/State/Zip Ellensburg, WA 98926	City/State/Zip_____
Phone #(509)933-2400	Phone #_____
Email Dental.reception@CHCW.org	Fax #_____

**Purpose for Release of Records (Please be specific): ☐Consult ☐Transfer of Care ☐Other ☐Self

Please send the following information (check applicable lines): Send to: DENTAL.RECEPTION@CHCW.ORG

_____ All health care information in my dental record

_____ Specific records related to the following condition: _____

_____ Specifically exclude: _____

Note: Under most circumstances, third party records will not be sent.

Read Carefully

I understand that my express consent is required for you to release information relating to sexually transmitted disease, HIV, mental health, and/or drug/alcohol abuse, pursuant to Washington Law RCW 70.24 ET. SEQ.

If I have been tested, treated, or diagnosed in connection with any sexually transmitted disease, or drug/alcohol abuse, and/or illness, you are specifically authorized to release to the person or entity named above all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded above. This release is good for 90 days and may be revoked in writing at any time provided the information has not yet been released. Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient or Legal authorized Signature _____ Date_____

Relationship (parent, legal guardian, representative, etc) _____ Date _____

Patient Signature (if over 17 years-of-age) _____ Date _____

IF A PATIENT HAS REACHED HIS/HER THIRTEENTH OR FOURTEENTH BIRTHDAY ONLY THE PATIENT MAY AUTHORIZE DISCLOSURE AS NOTED BELOW:

Consent of Minor (Age 13-17 years-of-age)

I understand that I am entitled to confidential treatment of information relating to treatment of contraception (14-17 years-of-age), pregnancy termination (14-17 years-of-age), sterilization (14-17 years-of-age), sexually transmitted diseases (14-17 years-of-age), mental health conditions (13-17 years-of-age), and/or drug/alcohol abuse (13-17 years-of-age) pursuant to Washington Law RCW 70.02.130 (1). I further understand that my signature below will authorize release of this information.

Patient Signature (If 13-17 years-of-age): _____ Date _____