



AUTHORIZATION TO RELEASE DENTAL INFORMATION

REASON FOR REQUEST	
<input type="checkbox"/> Personal	<input type="checkbox"/> Permanent Transfer to a New Dental Care Team
<input type="checkbox"/> Dental Care	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Benefits	

Patient Name			
Birth Date		Social Security # (Last 4 Digits)	
Current Address			
Phone Number		E-mail Address:	

I AUTHORIZE INFORMATION RELEASE FROM:
<i>Name of Facility/Provider Sending Information</i>
<i>Address of Facility/Provider</i>
<i>City, State, and Zip Code</i>
Note: If addresses are not provided, it may cause a delay in your request.

INFORMATION TO BE RELEASED TO:
<i>Name of Facility/Provider Receiving Information</i>
<i>Address of Facility/Provider</i>
<i>City, State, and Zip Code</i>
<i>Phone #</i> <i>Fax #</i>

TYPE OF INFORMATION TO BE RELEASED (SELECT ALL THAT APPLY)	
<input type="checkbox"/> Chart Notes	<input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Other: _____
DATES OF SERVICE (SELECT ONE OF THREE OPTIONS)	
<input type="checkbox"/> Most Recent Visit	<input type="checkbox"/> Last 2 years <input type="checkbox"/> From (MM/DD/YYYY) To (MM/DD/YYYY)

Your healthcare and payment for that healthcare cannot be conditioned upon receipt of this signed Authorization unless your healthcare or treatment is for the purpose of creating health information about you to be disclosed to a third party; or for the purpose of research. You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization, we will no longer use or disclose information about you for reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission. To revoke this Authorization, please send a written statement to Neighborhood Health Center ATTN: Risk and Compliance, 7320 SW Hunziker Rd, STE 300, Portland, OR 97223, that identifies the date you signed this Authorization, the recipient of the information identified in this Authorization and state that you are revoking the Authorization. This Authorization will expire on the earlier of one year from the date of signing, or the end of the period reasonably needed to complete the disclosure for the above-described purpose.

Signature of Patient or Patient's Legal Representative

Date

Print Patient's Name or Name of Patient's Legal Representative

Relationship to Patient (write in "Self" if you are the patient)

OFFICE USE ONLY	
<i>Signature of Staff Member Assisting Patient</i>	<i>Date</i>
<i>Title of Staff Member Assisting Patient</i>	