# Richardson DMD, Inc.

Dr. William Richardson
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Phone: (907)226-2218 Fax: (907)226-2310
richardsondmd@alaska.net

## Authorization to Release Health Care Information

Patient Name:_____ Date of Birth: _____/_____/_____

I, _____, hereby authorize the doctor and staff to release
*Patient Name (or Parent/Legal Guardian)*

health care information of the patient named above.

**RELEASE: ☐ FROM ☐ TO**

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Fax: 907-226-2310
Email: richardsondmd@alaska.net

**RELEASE: ☐ FROM ☐ TO**

Name: _____
Address: _____
Phone Number: _____
Fax Number: _____
Email: _____

☐ **By initialing here, I am acknowledging I am transferring care from Richardson DMD, Inc. to the practice listed above.**
Initials

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays, and any other records which pertain to me.

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This authorization expires one year after the date it is signed. I understand that I can cancel this authorization to the extent allowed by law, by submitting a request in writing. If I do, I understand that the doctor or practice may have already released information about me after I gave permission.

_____ _____/_____/_____
*Signature of patient, legal guardian OR authorized representative* *Date Signed*

_____
*Relationship if signed by parent, legal guardian, or authorized representative*