## Richardson DMD, Inc. Dr. William Richardson

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## **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	RELEASE: ☐ FROM ☐ TO
Richardson DMD, Inc.	Name:
412 E Pioneer Ave. Ste. 2 Homer, AK 99603	Address:
Phone: 907-226-2218	Phone Number:
Fax: 907-226-2310	Fax Number:
Email: richardsondmd@alaska.net	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.	
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 representation Relationship if signed by parent, legal guardian, or authorized to	

IMPORTANT WARNING: The information that follows is intended for the use of the person and/or entity to which it is addressed. This information may be confidential and privileged; the disclosure of which is governed by applicable federal and state laws. If you are not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution, or copying of this information is STRICTLY PROHIBITED.

IF YOU HAVE RECEIVED THIS MESSAGE IN ERROR, PLEASE NOTIFY US AT (907) 226-2218 IMMEDIATELY AND DESTROY THE RELATED MATERIALS.