cooper moss
ADVANCED DENTISTRY

Dental Records Release Form

Patient's Name: _____ Date of Birth:_____

Previous Name: _____

Dentist or Practice Name: _____

Phone Number: _____

Please forward any of the following information to our office: Panorex or FMX, BWX, Perio Charting:

Cooper Moss Advanced Dentistry
1105 4th Ave E., Ste: A
Olympia, WA 98506
360-357-8075
Appts@coopermossdentistry.com

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

Signature of patient or patient's representative Date signed

Relationship or status if signed by anyone other than patient (parent, legal guardian, etc.)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED.