

Lifetime Dental Care
Michael Breier, D.M.D., P.C.
2469 Queensgate Dr
Richland WA 99352
(509) 628-1144 Phone
(509) 628-1161 Fax
email:staff@lifetimedentalcaretricity.com

Patient's name _____ Date of birth _____

SSN/ID# _____ Previous name _____

I request and authorize _____ to release the following
healthcare information of the above named patient to:

Office name: _____

Address: _____

City, State: _____ Zip Code: _____

Phone: _____

This request and authorization applies to:

Health care information relating to the following treatment, condition, or
dates of treatment.

All health care information

Other

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 authorized representative

Date signed

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

This form expires 90 days after the date it is signed