Office of Dr. Olesya Z. Salathe DMD

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____ DOB: _____

Patient Address: _____

_____

Associated family members: _____

I, _____, request and authorize _____ to release health care information of the patient(s) named above. Please provide it to:

Dr. Olesya Z. Salathe
863 W Main Street - PO Box 657
Molalla, OR 97038
Email: scheduling@drsalathe.com Fax: 503.893.3111
Questions? Call us at 503.829.9731

This request and authorization applies to:

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

_____

__X_ Most recent radiographs __X__ Full mouth radiographs

__X_ Bitewing radiographs

__X__ Other: _Pano if available, Perio charting if available_____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits. I may inspect or copy any information disclosed under this authorization.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient may be prohibited from disclosing health information under other applicable state or federal laws and regulations.

_____ _____
Signature of individual or legal representative Date

_____
Relationship to patient