Authorization to Release Health Care Information

Patient's name: _____ Date of birth: _____

SSN: _____

Additional family members: _____

I request and authorize Stanley Cho DDS PLLC to release health care information of the patient or patients named above to:

Name: _____

Address: _____

City, State: _____ Zip code: _____

This request and authorization applies to:

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

_____

_____ All health care information.

_____ Other: _____

_____ _____
Signature of patient or patient's authorized representative Date Signed

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

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IS SIGNED.
Please allow 5 working days to process your request.