CAMAS DENTISTRY

Authorization to
Duplicate, Use or Disclose Protected Health Information

Payment for records duplication is due at the time of request. Duplication of records will be processed within 14 days of receipt of payment. If you are unable to deliver this authorization for records duplication to your dental office, completed authorization forms can be mailed with payment to:

Camas Dentistry
155 NE 192nd Ave, Ste 105, Camas WA 98607

I authorize the dentist and his/her staff to duplicate, use, or disclose my protected health information as described above. Authorization will expire in one year from the date this authorization form is signed.

I authorize my health information to be shared with the following individual/s on my behalf:

First and Last Name: _____ Relationship: _____

First and Last Name: _____ Relationship: _____

First and Last Name: _____ Relationship: _____

I authorize messages and other communication regarding my dental related appointments to be left using the following methods:

☐ Cell Phone ☐ Email ☐ Work ☐ Home Phone

Patient First and Last Name (print): _____

Guardian First and Last Name (print): _____

Patient/Guardian Signature: _____ Date: ___/___/___