Authorization to Release Dental Information

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Patient's Name: _____ DOB: _____ Telephone: _____

Mailing Address: _____ City/ State/ Zip: _____

Please **SEND** the following information **TO:**

Name of Provider/Organization/Person:

_____

Telephone Number:

_____

Street Address:

_____

Fax Number:

_____

City/State/Zip: _____

☐ By Fax ☐ Email (**Encrypted** and will expire after 7 days): **mmendoza@avhc.org**

I specifically authorize release of the following information:

- X-Rays
- Other Images

Notes:

_____

_____

- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: **Anderson Valley Health Center @ 13500 Airport Rd. Boonville, Ca. 95415**
- My revocation will take effect upon receipt, except to the extent those others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

Patient or Authorized Representative of the Patient:

Signed: _____ Print Name: _____

Relationship to Patient:_____ Date: _____

PLEASE KNOW IT MAY TAKE UP TO 2 WEEKS FOR RECORDS TO BE SENT.

THANK YOU FOR YOUR PATIANCE.

Dental Health

At Anderson Valley Health Center

13500 Airport Rd. Boonville, Ca. 95415 or PO Box 338 Boonville, Ca. 95415

Telephone: (707) 895-3477 or Fax: (707) 895-2035