AUTHORIZATION FOR RELEASE OF PATIENT RECORD INFORMATION FROM

Storybook Dental

Name of Patient:

_____

Address of Patient: _____

Number & Street

Apt.

_____

City

State

Zip

Patient Date of Birth:___/____/____

I hereby authorize the following provider(s) _____

the right to RELEASE TO:

_____Dr. Ronald Hsu Storybook Dental_____

2115 SE 192nd Ave. Suite 106 Camas, WA 98607_Phone:360-216-1130_____

_____Email: contact@storybookdental.com_____

Storybook Dental requests the following information:_____

_____

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below. Storybook Dental, by releasing authorized information, is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

_____**Parent or Legal Guardian Signature**

_____**Date**

2115 SE 192nd Ave Suite 106
Camas, WA 98607
Phone: 360-216-1130 Fax: 360-216-1125

Storybook Dental
HEALTHY SMILES FOR BRIGHT FUTURES