



## Authorization to Release Health Care Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release dental

records of the patient name above to:

**Riverside Dental  
Eric P. Messinger, DDS, PS  
2016 NE 3rd Avenue  
Camas, WA 98607**

For offices that wish to send digital x-rays, please send to [messingeroffice@comcast.net](mailto:messingeroffice@comcast.net)

The purpose / reason for release of information is as follows:

\_\_\_\_\_

This request and authorization applies to:

\_\_\_\_\_ Dental records relating to x-rays, perio charting, SRP, and prophy dates:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of patient or patient's authorized representative

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

**THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED.**