AUTHORIZATION TO DUPLICATE, USE OR DISCLOSE
PROTECTED HEALTH INFO
(Please print legibly)

Patient Name: _____ Date of Birth _____

Patient Address: _____

_____

Patient Phone: _____

Description of items requested: _____

_____

I AUTHORIZE DR GOLD'S OFFICE TO DUPLICATE OR DISCLOSE MY PROTECTED HEALTH INFORMATION AS DESCRIBED ABOVE TO: _____

PHONE: _____ EMAIL: _____

ADDRESS: _____

THIS AUTHORIZATION WILL EXPIRE IN 90 DAYS UNLESS I REVOKE IT EARLIER BY WRITTEN REQUEST.

Patient or Guardian Signature: _____ Date: _____

Return this form to: DR GOLD DDS 5100 Grove ST #A Marysville WA 98270
Fax: 360-653-6835 Email: scheduling@bethagolddds.com