AUTHORIZATION TO RELEASE OR OBTAIN HEALTHCARE INFORMATION

Drs. Toillion, Garabedian, & Herzog
418 East 30th Ave.
Spokane, WA 99203
Phone (509)624-1182
Fax (509)624-0823

Patient Name (s): _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

I authorize Drs. Toillion, Garabedian & Herzog to release/obtain health care information of the above named patient(s) to/from:

Name: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____

This authorization applies to:

_____Health care information relating to the following treatment, condition, or dates of treatment:

_____Any current dental x-rays (3 years for last pano or 1 year for last bw's)

_____Other: _____

I understand that my consent is required to release or obtain any health care information relating to testing, diagnosis, and/or treatment.

_____ _____

Signature of patient/parent or authorized person Date signed