release of records

WILLIAM MURDOCH, DDS
GENERAL DENTISTRY

I, _____ hereby authorize
PATIENT OR PERSONAL REPRESENTATIVE

_____ to disclose and provide copies of
PREVIOUS PRACTICE OR DENTIST NAME

the following protected health information which includes radiographs, chart notes, periodontal charting or any other clinical treatment records that detail my care provided by the above named person or entity to:

William B.L. Murdoch, D.D.S. - General Dentistry
120 E. Birch St., Suite 4, Walla Walla, WA 99362
info@wmurdochdds.com

I understand that I have the right to revoke this authorization at any time by sending written notification to Dr Murdoch. I understand that any revocation is not effective to the extent that Dr. Murdoch has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to:

- Inspect or copy my protected health information to be used or disclosed as permitted under federal and/or state law.
- Refuse to sign this authorization

I understand that Dr. Murdoch, or staff members of William B.L. Murdoch, D.D.S— General Dentistry will not condition my treatment on whether I provide authorization for the requested use or disclosure, except under the following circumstances:

- When the provision of care by Dr. Murdoch is solely for the purpose of creating protected health information for disclosure to a third party, when such disclosure is contingent upon my authorization.

X _____ _____

PATIENT OR PERSONAL REPRESENTATIVE **DATE**