# AUTHORIZATION FOR DISCLOSURE OF INFORMATION

**PEARLY WHITES LASER DENTISTRY**

Dr. Teresita Mandapat, DDS ~ 4041 Ruston Way Suite #103 ~ Tacoma, WA 98402
Phone 253-761-4041 Fax 253-761-1112

I _____ hereby authorize Dr._____ to disclose the following protected health information to Dr. Teresita Mandapat.

Please send my records including x-rays, periodontal charting, last dental hygiene procedures as well as any other pertinent information to Dr. Mandapat.

_____ _____

Signature of patient or personal representative Date

_____

Printed name of patient or personal representative