Authorization for Release of Dental Records

I authorize the release of my children's dental records to:

_____

(Name of Dentist or Clinic)

_____

(street address) (city) (state) (zip)

_____

(phone number) (fax number)

_____

(email address)

Patient Information:

_____

(patient name) (date of birth)

_____

(patient name) (date of birth)

_____

(patient name) (date of birth)

_____

(patient name) (date of birth)

_____

Signature of Parent/Legal Guardian **Date**

919 State Ave. #104
Marysville, WA 98720
(360) 659-8100

14090 Fryelands Blvd. SE, Ste. 348
Monroe, WA 98272
(360) 863-8700

9421 N. Davies Road, Ste. A
Lake Stevens, WA 98258
(425) 367-4149

7104 265th St. NW #110
Stanwood, WA 98292
(360) 339-8000