Authorization for Release of Records

Patient Name: _____ DOB: _____

Address: _____

City/State: _____ Zip: _____

Phone:_____

Release my dental records: To ☐ From ☐

Office Name : _____

Phone: _____

Fax: _____

Email :_____

Adventure Dental

900 NE 139th St. Suite #106

(360) 604-9000

FAX: (360)573-1417

info@adventuredental.com

By my signature, I authorize release of dental records.

Signature of Parent/ Guardian: _____ Date: _____

Printed Name: _____ Relationship to patient: _____