Bellevue Dentist

RELEASE OF RECORDS

Patient Name: _____
Date of Birth: _____

I authorize the staff of _____ to release, and transfer, my dental care information (all x-rays, hygiene visits and periodontal charting and any pending treatment) to the name below:

Bellevue Dentist
14645 Bel-Red Rd, Suite 100
Bellevue, WA 98007

_____
(Signature of the Patient, or patient's representative)

_____
(Date Signed)