Authorization to Release Patient Records

I authorize my previous provider to disclose the following private information to the dental office, listed below, for records and diagnostic purposes:

Previous Office:

Name: _____

Address: _____

Phone #: _____

Fax/E-mail: _____

Release to:

Canyon Park Dental • (425)485-6540

22833 Bothell-Everett HWY, Ste 205

Bothell, WA 98021

canyonparkdental@yahoo.com

Person authorized to make the request for records:

Patient Name:_____Relationship:_____

Signature:_____ Date: _____ /_____ /_____