AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I, (print patient or guardian name) ______________________________, hereby authorize the office of ____________________________ to release my last taken radiographs (bitewings and FMX/Pano) to:

Dr. Carson Calderwood

Snoqualmie Falls Dental

8026 Douglas Ave SE, Suite 200

Snoqualmie, WA 98065

Email: office@snoqualmiefallsdental.com

Fax: (425)449-5942

Signed (patient or guardian name): ____

Printed name (patient or guardian name): ____