AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I, (print patient or guardian name) _____, hereby authorize the office of _____ to release the following medical documents to the following office:

- ☐ X-rays
- ☐ Chart Notes

Dr. Carson Calderwood
Snoqualmie Falls Dental
8026 Douglas Ave SE, Suite 200 Snoqualmie, WA 98065
Email: office@snoqualmiefallsdental.com
Fax: (425) 449-5942
Phone: (425) 831-1790

Signed (patient or guardian name):

_____

Printed name (patient or guardian name):

_____