AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient or Guardian Name: _____

Signature of Patient or Guardian: _____

I authorize the following dental office to release my dental records (radiographs and chart notes) to Snoqualmie Falls dental.

Previous Dentist or Dental Office: _____

Address: _____

_____

Email, fax and/or phone: _____

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