RECORD RELEASE FORM

Date_____

TO: _____

ADDRESS: _____

CITY:_____STATE:_____ ZIP:_____

PHONE: _____ FAX: _____

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they are transferred to:

Art of Pediatric Dentistry
Alicia K. Wong, DMD, MPH
914 140th Avenue NE, Suite 101
Bellevue, WA 98005
T: 425-401-1147 F: 425-484-6424
office@artofpd.com

Records Requested:_____

Name(s) of Patient:_____

Signature of Parent/Guardian:_____ Date: _____