RECORDS RELEASE/REQUEST PERMISSION FORM

To: ____
Dentist/Denturist/Doctor/Hospital/Care Facility

____
Address

____
City, State, Zip Code

____
Phone, Fax, Email

I: ________________________________
Patient Name

hereby authorize the release of my dental records and any current dental x-rays to be sent to:

Wonder Family Dental and Dentures
19410 8th Ave NE Suite 102
Poulsbo, WA 98370
Phone: (360) 779-1566
Fax: (360) 779-6879
Email: contact@wonderdentaldentures.com

________________________________ ____________________
Signature of Patient/Parent/Guardian Date