Commencement Bay Dentistry

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Authorization for Release of Dental Records and X-rays

I, (print patient name or guardian name) _____ hereby authorize the doctors and staff of Commencement Bay Dentistry to release records or knowledge concerning my dental health to:

Full Dr. Name: _____

Street Address: _____

City, State, Zip: _____

Phone #: _____

Fax #: _____

Email of transfer office: _____

Signed (patient and/or guardian): _____

Printed Name (patient and/or guardian): _____

Date: _____

Notes:_____
_____
_____