Dr. Megan Miller, D.D.S., P.S.
2312 North 30th Street, Suite 202
Tacoma, WA 98403

Phone: 253-272-2900 Fax: 253-404-0684

Authorization for release of dental records and x-rays

I, (print patient name) ____ hereby authorize the doctors and staff of ______________________________ release records or knowledge concerning my dental health to:

Dr. Name: Dr. Megan Miller

Street Address: 2312 North 30th Street Suite 202

City, State, Zip: Tacoma, WA, 98403

Phone#: 253-272-2900

Fax: 253-404-0684

Email: cbdentistry@comcast.net

Signed (patient and/or guardian):____

Printed Name (patient and / or guardian):____

Date: _______________________

Notes:
____
____
____