AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

PATIENT INFORMATION:

Name ________________________________ Date of Birth ______________

Adress ____

City: _______________________ State ___________ Zip _______________

Phone _____________________

RELEASE MY DENTAL RECORDS FROM:

Dr. ________________________________

Phone/Fax ____________________________

TO:

Chandur Wadhwani, D.D.S., M.S.D.
12715 Bel-Red Rd Suite 201
Bellevue, WA 98005

425-453-1117 (phone)
425-462-1878 (fax)
nwprosth@live.com

Please release a copy of all my dental records, including but not limited to, x-rays and perio charting.

BY MY SIGNATURE I AUTHORIZE RELEASE OF DENTAL RECORDS

Patient _________________________________ Date _________________________