RELEASE OF RECORDS
AUTHORIZATION

Date:_____

I hereby authorize the release of dental records for _____
(please choose one):

☐ **TO** ☐ **FROM**

Doctor or Patient's Name_____

Address _____ City_____ State _____ Zip_____

Phone_____ Fax_____

Email address to send records to _____

☐ **TO** ☐ **FROM**

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Bothell, WA 98021
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(425) 806-8140 (fax)
Info@goldwiredental.com
Emailing us images is preferred

_____
Patient name printed

_____
Patient/Guardian Signature