Malinda Lam-Gershony, DDS, PLLC
16710 NE 79th ST-Suite 100
Redmond, WA 98052
425.867.1484(p)
425.895.9555(f)

Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____, hereby

authorize the doctors and staff of _____to release records or knowledge

concerning my dental health to:

Full Dr. Name Malinda Lam-Gershony, DDS

Street Address 16710 NE 79th ST-Suite 100

City, Zip Code Redmond, WA 98052

Email info@redmonddentalsmiles.com

Practice telephone number: 425.867.1484

I specifically request that you release copies of: (Please Circle)

-X-rays -Treatments Notes

Signed (patient or guardian name) _____

Printed name (patient or guardian name)_____