

## Records Release

I authorize Issaquah Valley Dental Care to release my records to :

☐ My Family

Name:

☐ My New Dentist

☐ My Phycsian

☐ My Dental Specialist

Address:

Via:

Phone:

☐ Mail

Fax:

☐ Fax

☐ Email

Email:

This consent is valid for a period of 6 months from date of release and includes release of :

☐ Health history.

☐ Diagnostic record (pictures, x-rays etc)

☐ Treatment plan & notes

☐ Other information requested.

Comments:

Signature

Patients Name

Date: