Records Release

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

- ☐ My Family
- ☐ My New Dentist
- ☐ My Physcian
- ☐ My Dental Specialist

Name:

Address:

Phone:

Fax:

Email:

Via:

- ☐ Mail
- ☐ Fax
- ☐ 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:

Print Form