ISSAQUAH VALLEY DENTAL CARE
1660 NW GILMAN BLVD, SUITE C1, ISSAQUAH, WA 98027

REQUEST FOR RELEASE OF RECORDS

I hereby authorize you to facilitate release of my dental records to the office named below to enable me continue my dental care.

Please release all available records

- ☐ Medical History
- ☐ Dental History
  - Treatment Rendered in the past.
  - Last date: BW, FMX and Hygiene.
- ☐ Diagnostic Records
  - Radiographs
  - Periodontal charts
  - Clinical Images
- ☐ Pending treatment needs if any.

Please send the above mentioned information via

☐ Mail to:
Issaquah Valley Dental Care
1660 NW Gilman Blvd, Suite C1
Issaquah WA 98027

☐ Fax: 425 392 1167
☐ Email: info@issaquahdental.com

Patients Name: Signature:
Date:

Instructions: Please send this form to your previous dental office and cc us for follow up.

www.issaquahdental.com
phone 425 392 4122 facsimile 425 392 1167