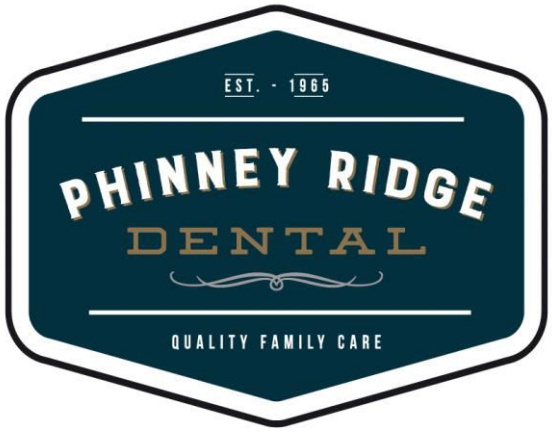

Authorization to Release Dental Records

Patient Name _____

Date of Birth _____

Address _____

Phone _____

Previous Dentist/Practice Name: _____

Office Phone # _____

Office Email _____

I hereby authorize the release of all my dental records, including current radiographs, periodontal charting, treatment history, and any other relevant information, to the following location:

Phinney Ridge Dental
Micah Bickel, DDS
7109 Greenwood Ave N Seattle, WA 98103

phinneyridgedental@gmail.com

By signing below, I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that my dental records will be sent to the provider listed above by mail or electronically. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

_____ _____

Signature **Date**

_____ _____

Name of Authorized Representative (If Applicable) *Relationship to Patient*