SEQUIM FAMILY DENTISTRY

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360-681-8884

Patient Name:_____

Date of Birth:_____

I authorize the release of the following information to be sent to _____
(name of office and phone number)

- ☐ X-rays
- ☐ Progress notes
- ☐ Periodontal chart
- ☐ Other_____

Please send records to (please check one):

- ☐ E-mail address: _____
- ☐ Fax number: _____
- ☐ Address: _____

Patient signature:_____ Date: _____