North Seattle Smiles

RECORDS RELEASE AUTHORIZATION FORM

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to North Seattle Smiles.

Date: _____

_____ _____

Print name of patient Signature of patient, parent or guardian if minor

Please send the following information as digital images via email:

- Full mouth series and panoramic x-rays taken within the past five years
- Bitewings and periapicals within the past two years
- Periodontal Charting
- Date of last root plane/scaling (if applicable)
- Other: _____

Thank you!

Please email to: North Seattle Smiles
info@northseattlesmiles.com

To contact us: Phone: 206.362.6116
Fax: 206.440.8411
Email: info@northseattlesmiles.com
Website: www.northseattlesmiles.com
Address: 907 N 130th St Seattle, WA 98133