

RECORD RELEASE FORM

Date _____

TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

I authorize the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

Art of Pediatric Dentistry
Alicia K. Wong, DMD, MPH
914 140th Avenue NE, Suite 101
Bellevue, WA 98005
Telephone: 425-401-1147

Records Requested: _____

Name(s) of Patient: _____

Signature of Parent/Guardian: _____

Date: _____