KirklandDental.com

Family & Cosmetic Dentistry

Exceptional Care Every Appointment

Dr. Teresa K. Yagi & Dr. Lauren J. Ma

AUTHORIZATION TO RELEASE DENTAL INFORMATION

I request and authorize_____ to release copies of my dental record and x-ray. I understand that my actual dental record, by law, belongs to before mentioned dentist. I understand that the information contained in the record belongs to me. I agree to accept copies of such records and to pay any fee(s) for duplication as required.

Release to: Kirkland Dental

Address: 11800 NE 128th Suite 520

Kirkland, WA 98034

Telephone Number: 425-820-0500

Email: info@kirklanddental.com

Print Patient Name_____

Patient Signature_____ Date____/____/ 20____

Date of Birth____/____/_____