REQUEST FOR RELEASE OF DENTAL OR HEALTH INFORMATION

I, _____Hereby grant permission to

_____
Name of previous Dentist

Address:

_____Zip_____

Phone # _____

Release information related to my health & dental history, and copies of my x-rays to: (Please choose one of the below)

- Dr. Christine Kim, 11066 5th Ave N.E., #105- Seattle, WA 98125 (206-362-6331)

- (Self): _____

_____Zip_____

- New Dentist: _____

_____Zip_____

I hereby release Dr. (previous) _____
From any liability related to disclosure of confidential and privileged information.

Signature: _____

Address: _____

Date: _____