Authorization to Release Dental Records

I, (print patient or guardian name) _____ herby authorize the release of my dental records to:

Soundview Family Dental
Dr. Eric Kitts, DDS
201 5th Ave South Suite 103
Edmonds, WA 98020
P: 425-563-6360 F: 425-563-6366
soundviewdental@gmail.com

Signature: _____ **Date:** _____

Printed Name: _____

Patient Name: _____ **Date of Birth:** _____

Address: _____

_____

Phone Number: _____

Previous Dentist: _____

Office Address: _____

_____

Phone Number: _____ **Fax Number:** _____

Reason for Release: _____

SOUNDVIEW
Family Dental
Eric D. Kitts, DDS