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Consent to Release Dental Records

To ______________________________

Address ______________________________

City ____________ State ____________ Zip ____________

Phone (______) ____________ Fax (______) ____________

I hereby authorize the release of my dental records, radiographs (X–rays), perio charting, treatment planning or other copies of dental notes relating to my dental treatment and request that they be transferred to:

Zachary J. Lester, DMD
7117 Stinson Avenue, Suite A
Gig Harbor, Washington 98335
P: (253) 851-6771 F: (253) 851-7281
E: info@lesterdental.com

Records can be sent via email (info@lesterdental.com) or snail mail.

Patient Name ______________________________ DOB _____ / _____ / _____

Signature ______________________________ Date _____ / _____ / _____