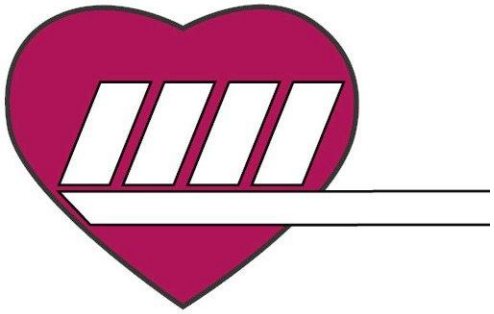

Carrie K. York, DDS
Family and Cosmetic Dentistry

7437 SE 27th Street,
Mercer Island, WA 98040
Phone: 206-232-2505
Fax: 206-232-8307
Email: frontdesk@carrieyorkdds.com

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: _____

Date of Birth: _____ Previous name: _____

I request and authorize: _____

_____

_____

_____

To release original dental records to:

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Please include BW within last 2 years, Pano or FMX within last 5 years, periodontal charting and any history of scaling and root planing along with the date of their last recall.

_____

Signature of Patient or authorized representative DATE

_____

Relationship or status if signed by anyone other than patient (parent, guardian, etc.)