

Children's Dental Center
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913 128 Street SW
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425 355 1136
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AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I, _____ hereby request and authorize
(Parent/Guardian name)

Olga L Ortuzar, DDS, MS, PS & Associates

To release my child/children dental records to:

(Name of Dentist) (telephone number) (email)

(Street) (city) (state) (zip)

(Name of parent) (telephone number) (email)

(Street) (city) (state) (zip)

.....

Patient Name DOB

Patient Name DOB

Patient Name DOB

Signature of parent/guardian Date

NOTE: To recipient of information. This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains. (Charges may apply for copies of records).

May fax back to: 425 355 0767 or E-mail to childdentist@frontier.com