

Children's Dental Center
Olga L Ortuzar, DDS, MS, PS & Associates
913 128 Street SW
Everett, WA 98204
425 355 1136
Fax: 425 355 0767

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I, _____ hereby request and authorize
(parent name)

Olga L Ortuzar, DDS, MS, PS & Associates

To release my child/children dental records to:

(Name of Dentist) (telephone number) (fax number)

(street) (city) (state) (zip)

(Name of parent) (telephone number) (fax number)

(street) (city) (state) (zip)

Patient Name DOB SSN

Patient Name DOB SSN

Patient Name DOB SSN

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).