



SWANSON

Dental Associates

Date: ____/____/____

Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) _____, hereby authorize the release records concerning (patient name(s): _____) _____ dental health and copies of all x-rays and all treatment notes to:

Swanson Dental Associates
1135 116th Ave NE Suite 580
Bellevue, WA 98004

Previous Dental Provider:

Dr. Name: _____

Street Address: _____

City, State & Zip Code: _____

Phone: _____ Fax: _____

Signed (patient or guardian)

Printed name (patient or guardian name)
