Release of Records Authorization

I, _____, give my authorization for

Dr. _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

to release my dental records to:

Lyly Fisher DDS, PLLC
406 Burnett Ave. S.
Renton, WA 98057

Phone: 425-271-5705
Fax: 425-271-0165
Email: info@lylyfisherdds.com

Signature: _____

Date: _____