Mountain View Dental
(509) 962-2755 PHONE
(509) 962-2750 FAX
info@ellensburgdentist.com

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Patient Date of Birth: _____/_____/_____

I authorize: _____

_____

_____

to release dental records; x-rays and treatment needs for the purpose of further dental treatment to:

Mountain View Dental
708 E. Mountain View Ave
Ellensburg, WA 98926

_____ _____/_____/_____
Patient (or Guardian) Signature Date