DENTAL RECORDS REQUEST

Patient Name: _____

I authorize Dr. _____

Phone # _____

Fax # (or Email) _____

To release my dental records (radiographs and periocharting) to:

Gerald Wolff, DMD, ABGD
Wilma Shen, DDS
4400 California Ave. S.W.
Seattle, WA 98116

Phone: 206 935-6286
Fax: 206 935-1326
E-mail: wolffscheduler@comcast.net

Patient (parent or guardian) **Date**

(Authorization must be provided by patient of legal age or by legal guardian)