510 Allen St
Kelso, Wa 98626
Phone (360)636-5170 Fax (360)636-0052

Release of Records

Patients Name:____________________________________Date of Birth_____________

Address:____

City___________________________State_________________Zip_________________

<u>RELEASE FROM LIABILITY FOR PATIENT ACCESS TO DENTAL RECORDS</u>

I hereby request that:

- Hilander Dental
- Other____

And/or responsible staff release

- Copies of X-rays
- Clinical Notes

- Send to :
  Name____

  Address:___________________________City______________State______Zip______

- Hilander Dental

I am having my records transferred for the following reason:

Signature_______________________________________Date_____________________

How records were released: Mailed____Hand Delivered____Emailed____Picked up___