



Authorization for Release of Dental Records

I authorize the release of my children's dental records to:

PUGET SOUND PEDIATRIC DENTISTRY
919 STATE AVE #104
MARYSVILLE, WA 98270
360-659-8100 (PHONE)
360-659-8133 (FAX)
TEAM@PUGETSOUNDMV.COM

Patient Information:

(patient name) (date of birth)

(patient name) (date of birth)

(patient name) (date of birth)

(patient name) (date of birth)

Signature of Parent/Legal Guardian Date