# Authorization for Release of Dental Records

I, (print patient/guardian name), ___________________________________, hereby

authorize release of my records to/from Dr. Delia Constantin, DDS

Please email, fax or mail a current copy of patient's PANO, BWX, FMX and Perio Charting.

Please email requested records to: info@bonneylakedental.com
Fax: (253) 863-5061
Mailing Address: **Bonney Lake Dental Center**, Dr. Delia Constantin, DDS
9925 214 Ave E, Suite A
Bonney Lake, WA 98391

(Enter the information of your previous or new dentist)

Dr: ________________________________________

Clinic: ________________________________________

Address: ________________________________________

________________________________________

Phone: ________________________________________

Fax: ________________________________________

Email: ________________________________________

Reason for leaving practice: _____________________________

Sign Name: _________________________ Date: _______________

Print Name: _________________________