IRWIN DENTAL CENTER

RECORDS RELEASE REQUEST FOR TREATMENT PURPOSES

Date _____

To _____
Doctor

Address _____

City _____ State _____ Zip _____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

IRWIN DENTAL CENTER
620 East 8th St.
Port Angeles, WA 98362
Telephone : (360) 457-0489

*Please email x-rays to appointments@irwindentalcenter.com

Please forward this request to your previous dentist prior to your dental appointment.

_____ _____
Signature of Patient, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient