WEISHAAR
SUE WEISHAAR . DDS

1005 N. Evergreen Rd Suite 101
SpokaneValley, WA 99216
PH: 509-922-3333 · FAX: 509-922-6533

REQUEST FOR RELEASE OF DENTAL RECORDS

TO DR: _____

FAX: _____

PHONE: _____

ADDRESS: _____

PATIENT NAME: _____

PREVIOUS NAME: _____

DATE OF BIRTH: _____

_____
PATIENT SIGNATURE

_____
PARENT OR LEGAL GUARDIAN OF MINOR UNDER AGE OF 18

Please send a copy of
ALL PERIO CHARTING and RADIOGRAPHS
of the above patient

AUTHORIZATION IS VALID FOR 90 DAYS FROM DATE OF REQUEST