J. BAYARD DuBOIS, D.D.S.

121 NORTH KENNEBECK AVENUE KENT, WA 98030 (253) 854-6300 FAX (253) 854-9976

DENTISTRY FOR
YOUR FAMILY

Release of Patient's Record Consent Form

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records to:

Name: _____
Address: _____
_____
Phone #: _____

Patient's Name: _____
DOB: _____

Address: _____
_____

Requesting:
FMX: _____
BW: _____

Patient or Guardian's Signature: _____
Date: _____

For Office Use Only:
Witness: _____