

**Clearwater Dental
Han and Rose**

5000 West Clearwater Avenue
Kennewick, WA 99336
Phone (509) 783-5000 | Fax (509) 783-8349

Authorization to release my information

I _____, DOB _____
(Patient or legal authorized individual)

authorize Clearwater Dental to release the following dental information to
_____. This includes all health care
information, current full mouth, pano, bitewing xrays, and periodontal charting,

Patient Signature _____ Date _____
(Legally authorized individual signature)

Please email records to info@clearwaterdental.com
or mail them to 5000 West Clearwater Avenue, Kennewick, WA 99336