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 _____ to release the
(Previous Dentist or Healthcare Provider)

following dental information to **Clearwater Dental**. This includes all health care information, current full mouth, panoramic, bitewing x-rays and perio 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