JEFF D. MALYON, DDS
14810 Lake Hills Blvd, Suite A-1
Bellevue, WA 98007
Office: 425-746-5929
Fax: 425-746-9870

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Please complete this form and send to your previous dentist. Thank you.

Patient Name: _____

Date of Birth: _____

Previous Dentist Name: _____

Phone: _____

I request and authorize the release of dental records to the following:

Jeff D. Malyon, DDS
Lake Hills Family Dentistry
14810 Lake Hills Blvd, Suite A1
Bellevue, WA 98007
E-mail: jeffmalyondds@yahoo.com

This request and authorization applies to:

_____ Most recent BW x-rays
_____ FMX or PANO from the last 3-5 years
_____ Perio Charting
_____ Major Treatment placement dates

_____ _____
Signature of Patient or Authorized Representative Date signed

_____
Relationship or Status if signed by other than patient.

This is a confidential document.
If you have received this document in error,
Please contact the send and shred immediately.