



SOUTHPOINT

DENTAL CENTER

1129 South Second Ave., Suite A, Walla Walla, WA 99362 (509) 522-2522

RELEASE OF RECORDS

I, _____ hereby request and authorize
_____ to disclose and provide copies of any
and all X-rays and clinical treatment records concerning my care to:

By mail: Southpoint Dental Center
1129 S. Second Ave., Suite A
Walla Walla, WA 99362
(509) 522-2522

By email: southpoint@gohighspeed.com

Signed _____ Date _____