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: contactus@southpointdentalcenter.com

Signed____Date________________