Distinctive Dentistry
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22315 Highway 99 N., Suite 1
Edmonds, WA 98026
(425) 771-3266 • www.DistinctiveDentistry.com

Patient Records Release

I give permission to Distinctive Dentistry and its employees to release the dental records for,

Boxes outlined in red are required

Patient First Name ____________ Patient Last Name ____________ Date ____________

Please release these records to:

- ☐ ***Dentist***
- ☐ ***Physician***
- ☐ ***Self***

Release to ____________

Address ____________

City ____________ State ____________ Zip ____________

Phone ____________ Fax ____________

Reason for Release:

Physical Submission - Please print the form, sign below and drop off or mail the completed form to our office.

Signature (patient or guardian) ____________ Relationship (if guardian) ____________ Date ____________

Initials ______ Patient Date of Birth ____________ Last 4 digits of Soc. Sec. No. ____________ email ____________

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