Kwon
FAMILY DENTISTRY

REQUEST FOR RELEASE OF RECORDS

I, _____DOB_____ request and give my

Permission to _____to provide

Paul Kwon, D.D.S.,
746 F Street SW, Quincy, WA 98848

any and all Information they request with respect to the dental treatment of

A photocopy of this release will be as effective and valid as the original.

Signed _____ Patient

Dated Signed _____

If needed send information to email: cindy@quincyfamilydental.com

Phone: (509) 787-1507
FAX: (509) 787-2100