-RECORDS RELEASE REQUEST-

Dear Dr.____ I authorize the release of my child's dental and medical records relevant to my dental treatment, or copies of such, and request that they be transferred to:

Dr. Victoria Vu

7800 27th st. Suit 101

Mercer Island WA 98040

info@mipediatricdentistry.com

(206).535.8189

Printed Patient Name:__________________________________

Parent/Guardian Signature:_________________________________

Records Release on_______________________
By____