Request for Release of Dental Records

Patient name to transfer:_____ DOB:_____

I, (print patient or guardian name)_____, hereby authorize _____ to release my dental records to:

BALLARD DENTAL CARE
JEFFERY C. COLE, DDS

6111 15th Ave NW, Seattle, WA 98107
p: 206.783.7700 e: ballarddentalcare@gmail.com

Patient/Guardian Signature:_____ Date:_____

Please forward any of the following that you have:
x-rays, periodontal charting, chart notes and photographs
to: **ballarddentalcare@gmail.com**