AUTHORIZATION TO RELEASE RECORDS

I authorize _____ to release my records to:

Mountain View Dental
Benjamin Crusan, D.D.S.
2 South 56th Place, Suite 202
Ridgefield, WA 98642
(360)887-1177 phone
(360)887-1178 fax
info@ridgefielddentist.com

Patient Name:_____

Patient Signature:_____

Date:_____

*Please forward any current x-rays to the above mailing or email address. If the x-rays are digital, we prefer that they are emailed. Thank You.