

## Release of Records Authorization

I, \_\_\_\_\_, give my authorization for

Dr. \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

to release my dental records to:

Lyly Fisher DDS, PLLC  
406 Burnett Ave. S.  
Renton, WA 98057

Phone: 425-271-5705  
Fax: 425-271-0165  
Email: [info@lylyfisherdds.com](mailto:info@lylyfisherdds.com)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_