Dr. William H. Raleigh, D.D.S.
206-935-5210
Fax: 206-932-5958
Email: drbillraleigh@aol.com

AUTHORIZATION FOR THE RELEASE OF MEDICAL/DENTAL RECORDS

I hereby authorize _____
Dentist or Practice name

_____ _____
Address *Phone*

to release and transfer dental records, including but not limited to x-rays and periodontal charting, for the following patient(s):

to:

William H. Raleigh, D.D.S.
4401 California Avenue S.W.
Seattle, WA 98116

Digital records may be emailed to:
drbillraleigh@aol.com

Thank you,

_____ _____
Authorized Signature *Date*