Authorization to Forward or Request Records

Patient Name: Date of Birth:

Patient Name: Date of Birth:

Forward Records To:

I authorize Nordstrom Family Dental or Wee Care Pediatric Dental to **send** my dental records and images:

To: ____

Address: ________________________________ State: __________ Zip Code:__________

Phone: (_____)____________________________ Fax:(______)________________________

Email: ____

Needed Sent: (Circle one please) ASAP (1Week Minimum) Upon Notification

Request Records From:

I authorize Nordstrom Family Dental or Wee Care Pediatric Dental to **request** my dental records and images:

From: ____

Address: ______________________________ State: ____________ Zip Code:__________

Phone: (_______)________________________ Fax:(______)___________________________

Email: ____

Patient has an appointment scheduled us on ________/________/________ @ ____________am/pm

____ _______/_______/________

Signature of authorized Person Date

____ ______________________

Printed name Relationship to Patient

Dr. Nordstrom, DDS: 907.357.6800 or Dr. Maixner DMD: 907.373.6000

1001 E USA Circle STE B Wasilla, AK 99654

Fax: 907.357.6878 Email: frontdesk@matsudentist.com