# *University Dental Associates*

4526 – 15th Ave NE
Seattle, WA 98105
Phone: (206)523-8094
Fax: (206)522-4634


## Authorization for Release of Dental Records

I, ______________________________________ am transferring my dental care to
(please print)
University Dental Associates. My appointment is on __________________________.

I request and authorize the release of the following dental records:

XX Dental radiographs:

- Bitewing and periapical x-rays within the past two years
- Full mouth x-ray and/or panelipse x-ray within the past 5 years

XX Periodontal charting

**Digital records can be sent to: info@udadental.com**

___________________________________________________ Date __________________
Signature of Patient or Legal Guardian

________________________________________________ Date ____________________
Signature of Patient or Legal Guardian