RELEASE OF RECORDS
AND X-RAYS

Date _____

I _____ authorize _____
to release my dental x-rays / records for the purpose of further treatment to:

David W Hopewell DDS PLLC
7614 195th St SW Ste 102
Edmonds, WA 98026
425-771-7233
Fax 425-776-5750

Please email records to: **office@drhopewell.com**

_____
Patient Signature or parent signature, if patient is a minor

_____
Print name

_____
Date signed