Authorization to Release Records and X-rays

Each adult patient must sign his/her own Authorization to Release Records form

Requesting records from:

Doctor: _____

Address: _____

_____

Phone _____ Fax _____

Authorized to release records and x-rays to:

Doctor: Max H. Molgard, Jr., DDS, FACP

Address: 6817 N. Cedar Rd, Ste 102

Spokane, WA 99208-4277

Phone (509) 327-4469 Fax (509)328-9902

Please email X-rays to: front@maxmolgard.com

Patient Information:

Your name: _____

Address: _____

_____

_____

_____

Patient Signature

_____

Date

This authorization is valid for 90 days.