Barbara L. Billings DDS
1025 S 320th, Suite 201
Federal Way WA 98003
Phone: 253-839-4636
Fax: 253-946-8286

REQUEST FOR RECORDS RELEASE

I ___________________________, hereby request and give my permission to provide dental records of the following family members.

Please send my/or records to: _____________________________________
At the following address:____
____

I/We are transferring our records for the following reason/s. (please circle or explain)

1. Change of insurance, office is no longer on my plan.
2. Moving out of area/state.
3. Closer to home/work.
4. Other (please explain)____________________________________
____
____

This authorization ends:

- ❑ In 90 days from the date signed
- ❑ On (date)___________________
- ❑ When the following event occurs:_________________________________

Signed:______________________________ Date:________________________

Home phone: _____________________Work phone:______________________