LISA A. BLOCK, D.M.D., M.S.
3519 56th ST NW, SUITE 140
GIG HARBOR, WA 98335
253.858.8581 FAX: 253.858.2189

X-ray/Release of Records Authorization

PATIENT NAME:__________________________________ **DATE OF BIRTH:** ___________

I, ______________________________, hereby authorize and request the release of
(Parent or guardian)
duplicate x-rays/records from:

____ Lisa A. Block, DMD, MS, PC
____ Dentist name: ____
Dentist address: ____
____

Please release x-rays/records to:

____ Lisa A. Block, DMD, MS, PC
____ Dentist name: ____
Dentist address: ____
____

(A $10.00 duplication fee is required.) *(Paid)* ☐

______________________________ ____________________
(Signature of Parent or Guardian) (Date)