

Dr. William H. Raleigh, D.D.S.

4401 California Ave SW
Seattle, WA 98116
206-935-5210
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AUTHORIZATION FOR THE RELEASE OF MEDICAL/DENTAL RECORDS

I, _____, authorize _____ to
release and transfer my dental x-rays and periodontal charting to
Dr. William H. Raleigh at the address below:

William H. Raleigh, D.D.S.
4401 California Avenue S.W.
Seattle, WA 98116

Thank you,

(Signature)

(Date)