First: Last:

I _____ authorize the release of my radiographs and dental records for the following individuals:

_____
_____
_____
_____
_____

Office Records Requested From (please include office name, address, phone number and email):

_____
_____
_____

Please send all records to:

Michael Kim, DDS
10033 N. Port Washington Rd., Ste 150
Mequon, WI 53092
Ph: (262) 241-5558
Fax: (262) 241-5545
Email: office@michaelkimdds.com

Signature_____Date_____

◯ I understand that checking this box constitutes a legal signature confirming that I acknowledge and understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.