REFLECTION DENTAL

Patient Authorization for Release of Dental Records

Date	
Patient Name(s)	
Patient DOB(s)	
Legal Guardian name if applicable	
Recipient (Individual or dental office) Name	
Recipient Email Address	
Patient or Legal guardian Signature	

I give authorization to disclose the following information:

☐ All dental information including x-rays

OR

☐ All dental information including x-rays specifically between these dates

Starting Date:_____ End Date:_____

Kunsun Lee DDS • B. "Lily" Kim DDS
222 Chalan Santo Papa Ste #304 Hagatna, GU 96910 • (671) 472-6824
reflectiondental.gu@gmail.com