Today's Date _____/_____/_____

AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

I authorize the following transfer of my medical/dental records.

FROM: Dentist/Practice:_____

Address: _____

_____

Telephone: _____

Email: _____

TO: Dentist/Practice: **Lee Dental of Arlington Heights**

Alisa You Yeon Lee DDS

Address: 637 E Golf Rd. Suite 205

Arlington Heights, IL 60005

Telephone: 847-593-6480

Email: info@leedentalah.com

Requested by:

_____ _____/_____/_____

Patient's Signature (or Legal Guardian) Date

Patient Name (please print): _____

Date of Birth: _____

Telephone: _____

Email: _____