Robert Cassell DDS
Justin Coffman DDS
Brian Wight DDS

Authorization to Release Records to Wasilla Dental Center

Records to be released from

Dentist/Dental office name _____

Address _____

Phone _____Fax _____

Records requested

☐ Panos ☐ Full mouth x-rays ☐ Bitewings ☐ Records

Patient name_____Date of birth _____

Patient Signature _____Date _____

(907) 376-5315
351 W Swanson Avenue, Suite 1, Wasilla, Alaska 99654
clinic@wasilladentalcenter.com
Fax (907) 376-7855