ANDREW B. WURTZ, D.D.S.
101 W CASCADE WAY, SUITE #205
SPOKANE, WA 99208-6000
Office 509-466-2595 Fax 509-466-6615
andrewbwurtzdds@comcast.net

RECORDS REQUEST/RELEASE

Patient_____

Address_____

City_____ State_____ Zip _____

Home_____ Cell_____ Work_____

I _____ hereby authorize the release of my:
(Pirint Name of Patient or Legal Guardian)

_____ X-Rays

_____ Records

_____ Photographs

Or copies of such, medical and otherwise confidential, by Dr Andrew Wurtz and/or his agents, and request they be **transferred (circle) from or to:**

Provider Name _____

Address _____

City _____ State_____ Zip_____

Phone # _____ Fax #_____

Please **forward** requested records (circle) from or to:

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101 W Cascade Way, Suite #205
Spokane, WA 99208-6000
509-466-2595, Fax 509-466-6615, andrewbwurtzdds@comcast.net

Patient Name _____
(Print)
From _____ To _____
(Date of Records)

_____ Date _____
Signature for Patient or Legal Guardian