



Children's DENTAL Village

Date: _____

I, _____ authorize Children's Dental Village
to release any pertinent information, records and x-rays regarding

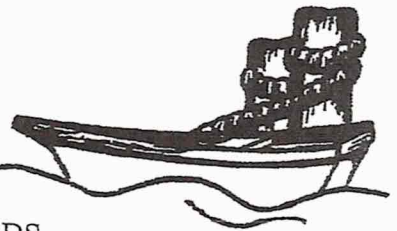
To: _____

Address: _____

Signature of Parent/Guardian: _____



Dr Jay Enzler & Dr Kirk Fuhriman, DDS
9302 N Colton, Ste 100 Spokane, WA 99218
(509)863-9460 ~ Fax:(509)868-0428





Children's DENTAL Village

Date: _____

To Whom It May Concern:

I, _____ authorize

_____ to release records, x-rays and
any pertinent information regarding _____ to:

Children's Dental Village
9302 N Colton, Ste 100
Spokane, WA 99218
(509) 863-9460 ~ Fax: (509) 868-0428

Signature of Parent/Guardian _____



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