KOKO HEAD DENTAL

ANN HASHITATE, DDS

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

I, (Patient Name) _____, hereby

authorize _____ to release my

records to the following provider:

Dr. Ann Hashitate, DDS
6700 Kalanianaole Hwy, Suite 107
Honolulu, HI 96825
staff@kokoheaddental.com

Print Patient Name: _____

Signature (Patient or Guardian): _____