KIK Dental
Be the Ultimate You

DENTAL RECORDS RELEASE AUTHORIZATION

I, _____, hereby authorize _____,

to release my dental records to:

KIK Dental, PLLC
403 S. 11th St., Ste 200
Boise, ID 83702

Office: 208-342-3440
Fax: 208-336-4740
Email: frontdesk.kikdental@gmail.com

Patient Name: _____

Signature : _____

Date: _____