Matthew S.M. Yun
Steven R. Powell
GENERAL DENTISTRY

Release of Records:
For patient transferring to the Office of Dr. Matthew Yun

Date: _____

I _____(patient/parent) hereby request and give my permission to Dr. Matthew Yun and his agents to obtain any and all patient records pertaining to the dental care of _____(patient) from:

Dr. _____

Address _____

City _____ State _____ Zip Code _____

Email Address _____

Phone Number _____

Patient Date of Birth _____

☐ Please send directly to their office at: 4111 Okemos Rd. Suite 202
Okemos, MI 48864
info@okemosdentistry.com

☐ I will pick up at your office. Please have ready by _____(date).

Thank you,

Signature of Patient _____