

*Dr. Stuart Yoon, DDS. PA*

**Authorization and Request for Records/Radiographs**

**Doctor:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

[ssyoondds@bellsouth.net](mailto:ssyoondds@bellsouth.net)

1396 Sand Hill Rd.

Suite 4

Candler, NC

28715

(828) 670-1966

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

*Thank you so much.*