Authorization to Release Dental Records

Dental Provider: _____

Address: _____

City, State, Zip: _____

Phone #, Fax #: _____

I, _____ am requesting my dental records to be forwarded to:

Barnes Dental, LLC
7325 SW Barnes Rd.
Portland, OR 97225
503-297-8866

-OR-

barnes.dental@hotmail.com

I give my permission for all information to be collected about me as a patient to be released to the above dental facility. Including any up to date BW, FMX/PANO x-rays and last DOS.

Thank You,

Patient Signature_____

Patient Name Printed_____

Date_____