AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Date:

Patient's Name & Date of Birth:

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Practice Releasing/Requesting:

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___ I authorize you, South Waterfront Dental, to release my records to the above practice.

___ I authorize the above dental practice to release my records. Please forward any radiographs and chart notes to:

South Waterfront Dental
Todd L. Beck, DMD
3671 SW River Parkway
Portland, OR 97239
info@southwaterfrontdental.com
503-841-5658

_____

Patient's signature