Dental Record Release Consent

To:

Dr. _____

Address: _____

_____

I _____ authorize that my dental records be released to:

Dr. Treavor Fisher
470 Highland
Coos Bay, Oregon 97420
treavorfisherdds@gmail.com

Portion of record to be released:

_____ Entire Dental Record
_____ Copy of most recent x-rays
_____ Other – Describe: _____

Patient's Name _____

Date of Birth _____

Patient's Name _____

Date of Birth _____

_____ _____

Signature of patient or guardian Date