GRESHAM
DENTAL GROUP

Patient Request for Records

Date: _____

To: _____
(Dentist)

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize the release of my x-rays/records or copies of such and request that they be transferred to:

315 NW Burnside Rd. Gresham, OR 97030
503-666-5484 Phone
503-661-1069 Fax
info@gresham-dentalgroup.com

_____ _____

Patient's Name (Print) Patient's Name (Signature)