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)