Records Release Consent

Date: _____

I hereby authorize the release of my x-rays/records or copies of such from:

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

and request that they be transferred to:

Dentist: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email address: _____

_____ _____

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