Patient(s) Name: ____

Date: __________________________________

To Whom It May Concern:

I authorize you to provide Oregon Dental Implant Residency any and all information with respect to my dental treatment or dental treatment of my family as listed below. A photograph of this release will be as effective and valid as the original.

Please release my complete chart including chart notes & dental x-rays to Oregon Implant Dental Residency office of request.

If digital radiographs are available, please mail to: mark your local office

☐ Hillsboro Office
518 SE Oak Street #100A Hillsboro, OR 97123
hillsboro@oregondentalimplantresidency.com

☐ Prineville Office
302 NE 7th St #100 Prineville, OR 97754
prineville@oregondentalimplantresidency.com

Thank you,

____
Signature of Patient or Patient's Legal Representative

Doctor records are being requested from:

Name:____

City/State of Practice:____

Phone/Fax:________________________ ________________________

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