Dental Records Release Form

Previous Dentist's Information:

Name _____ Phone _____

Address _____

_____

Email _____

I/We hereby authorize the release of records for the following patients

_____to:

_____ The following name and address

_____

_____

_____

Email: _____

_____ Behind the Smile Dentistry for Children
14795 SW Murray-Scholls Drive, Suite 116
Beaverton, OR 97006
Phone 503-579-0304
Fax 503-579-7866
admin@behindthesmile.com

_____ Behind the Smile Dentistry for Children
2380 NW Amberbrook Drive
Hillsboro, OR 97006
Phone 503-641-8800
Fax 503-352-0721
admin@behindthesmile.com

(Please include all current x-rays, perio charting, & date of last prophy and/or perio tx)

Guardian's name (printed) _____

Guardian's signature _____

Date _____