Request for Release of Information: (Individual)

Name of patient _____ **Date of birth** _____

I hereby request and authorize the release of records:
FMX, B/W, Perio Chart

The release of records from:

_____

Name of Doctor _____ **Email address**

Office phone _____ **Office Fax** _____

Please forward records to: **Evergreen Family Dentistry**
1791 NW 173rd Ave #110
Beaverton, OR 97006
info@evergreendentistry.com
Office: 503-531-8844 Fax: 503-466-9067

_____

Patient Signature or Guardian Signature _____ **Date** _____