



EVERGREEN

**FAMILY DENTISTRY
& ORTHODONTICS**

Records Release Request

Patients Name: _____ DOB: _____

Reason for transfer: _____

I hereby request and authorize _____
to release my dental records: (Office name)

- FMX
- BWX
- Perio Chart

Phone Number

Fax Number

E-Mail

Please forward records to: **Evergreen Family Dentistry & Orthodontics**
Dr. Derek Youngblood DMD, PC
Dr. Dharmini Pathmanathan DMD, PhD

info@evergreendentistry.com

**17305 NW Corridor Ct., Suite 150
Beaverton, OR 97006**

Office: (971)770-3455 Fax: (503)466-9067

Signature: _____

Date: _____