Dental Records Release

Date: _____

To: _____

(PRIOR DENTAL OFFICE NAME)

Address: _____

City: _____ State: _____ Office Phone #: _____

I authorize the release of dental records, x-rays and copies of such, and request that they be transferred to:

Bloom Pediatric Dentistry
201 SE Washington Street, Suite A
Dallas, OR 97338
Phone #: 503-507-0996 Fax 503-831-0532
E-mail: office@bloompediatricdental.com

_____ _____

Please print name of Patient | Patient Date of Birth

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Relationship to Patient