Authorization to Provide Copies of Records and X-rays

I hereby authorize the disclosure of information contained in or related to my dental or medical records and x-rays or those records and x-rays of my dependent, listed below, which are in the possession of my dentist. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to provide copies of these records and x-rays to the person or persons designated below.

Patient Name (Print)	DOB (MMDDYY)	Patient Name (Print)	DOB (MMDDYY)
Patient Name (Print)	DOB (MMDDYY)	Patient Name (Print)	DOB (MMDDYY)
Patient Name (Print)	DOB (MMDDYY)	Patient Name (Print)	DOB (MMDDYY)

Responsible Party Signature ____________________ Date ________

Responsible Party Signature ____________________ Date ________

Previous Dentist:

Name of clinic/person(s): ____________________

Address : ____________________

Phone: ____________________

Fax: ____________________

Please send records to:

Hillside Dental at Bethany

15160 NW Laidlaw Road, Suite 202

Portland, Oregon 97229

records@bethanydentistpdx.com (please email records if possible)

Caring dentistry, latest technology

Andrew Forster, DDS

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