Request for Release of Records

Date: _____

I hereby authorize the release of my dental records or copies of such and request that they are transferred.

To (Doctor or Hospital): _____

Address: _____

City: _____ State: _____ Zip: _____

From (Doctor or Hospital): _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Name: _____

Date of Records: _____

Patient Signature: _____

Sunridge Dental Care
14679 SE Sunnyside Rd Suite D
Happy Valley, OR 97080
(503)427-9770 | SunridgeDC@mydentalmail.com