AUTHORIZATION TO RELEASE PATIENT RECORDS

Exceptional Needs Dental Services
4707 SW Kelly Ave., Ste. 205
Portland, OR 97239
Phone: (503) 295-1201
Fax: (503) 295-1211

I, ____, hereby authorize and request

Dr. ___________________________ to release to:

____
Name of Dentist/or Clinic

____
Address (mailing) City State Zip

____
Phone

All records concerning finds and treatments of:

____
Patient or Patient's name

I hereby release Dr. _______________________________ from any liability related to disclosure of confidential or privileged information.

Signature ____
(Patient or person authorized to consent for the patient)

Address ____Date______________