Authorization to Release Dental Records and Radiographs

To Whom It May Concern:

I, _____, hereby authorize and request Dr._____ to send or E-mail copies of all dental radiographs, Perio Charting and summary of dental treatment records for the above patient and family to:

Carrie B. Laird, DMD & Lisa Strauch, DMD, MDSc
454 "A" Avenue
Lake Oswego, OR 97034
503-636-3066
E-Mail: info@lairdspink.com

IF YOU HAVE DIGITAL FILMS, PLEASE SEND EACH FILM IN AN INDIVIDUAL J-PEG FILE.

I hereby release the above mentioned doctors from any liability related to disclosure of confidential or privileged information.

Signature: _____
Address: _____
_____
Phone: _____
Date: _____