

**PLEASE MAIL OR FAX RECORDS REQUESTS TO:**

David E. Doyle, D.D.S.

10121 SE Sunnyside Road, Suite 320

Clackamas, OR 97015

Phone 503-786-5080

Fax 503-786-3483

**AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS:**

I, (print patient or guardian name) \_\_\_\_\_,

hereby authorize the doctors and staff of David E. Doyle, DDS to release dental records

for \_\_\_\_\_, \_\_\_\_\_  
(patient name) (patient name)  
\_\_\_\_\_ to:  
(patient name) (patient name)

Full Dr. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, St, ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ fax: \_\_\_\_\_

e-mail address for digital x-rays: \_\_\_\_\_

I specifically request that you release copies of:

\_\_\_\_\_ Dental x-rays ( including copies of Panoramic films  
and any other exposures less than 12 months ago)

\_\_\_\_\_ Treatment notes ( including services rendered and  
dates of service)

I hereby consent to the release of the above information. I understand that such information cannot be released without my consent.

Signed: \_\_\_\_\_  
patient, parent or guardian name

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

A photocopy or fax copy of this release is as valid as the original