11411 SE Sunnyside Road, Suite 101 Clackamas, OR 97015 503-855-5100

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND X-RAYS TO SUNNYSIDE DENTISTRY FOR CHILDREN

I, (print parent or guardian name) _____,
hereby authorize the doctors and staff of _____
(PREVIOUS DENTAL OFFICE)

to release dental records for:

_____	_____	_____	_____
(patient name)	(patient DOB)	(patient name)	(patient DOB)
_____	_____	_____	_____
(patient name)	(patient DOB)	(patient name)	(patient DOB)

To: Sunnyside Dentistry for Children
11411 SE Sunnyside Road, Suite 101
Clackamas, Oregon 97015
Telephone: 503-855-5100 Fax: 503-826-5196 E-Mail: info@sunnykids123.com

I specifically request that you release copies of:

_____ Current Dental x-rays (Including panoramic films and other exposures less than 12 months ago)

_____Treatment History (Including services rendered and dates of service)

Reason for transferring_____

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

Printed Name: _____Date: _____

Signature: _____
Patient (over age 18), parent or guardian name

A photocopy or fax copy of this release is as valid as the original. This release form is valid for 6 months from the signed date.