RELEASE OF INFORMATION REQUEST

Date: _____

I _____ Hereby request and authorize

_____ Phone number: _____
(Name of prior dentist/office)

Email: _____

to release all records of FMX, BWX, perio chart to Summercrest Dental.

Patient Name: _____ Date of Birth: _____

Other Family Members: _____ Date(s) of Birth: _____

X _____
Signature of Patient or Guardian
Each adult must sign permission to forward records for self (as per Federal Privacy Act)

*Please send records to: **info@summercrestdentistry.com** BEFORE: _____
Date of appointment

Thank you!
16400 SW Hart Rd. Suite A
Beaverton, OR 97007
(503)649-7701