AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient's Name _____ Date _____

I hereby request and authorize the release of all information, without limitations, regarding any dental treatment needed.

This includes photocopies of x-ray findings, diagnosis, treatment, and prognosis.

I request that you release the above information to:

Lisa A. Snider, D.M.D. DBA: 181 Dental
(Fill in name of patient or subsequent doctor or attorney)

116 S.E. 181st Ave. Mailing address: 465 N.E. 181st Ave., #615, Portland, OR 97230
Address

Portland	OR	97233
City	State	Zip

Email: Dental_181@yahoo.com

Patient's (or Legal Guardian's) Signature _____ Date _____