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GEARHART DENTISTRY RELEASE OF RECORDS

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

I hereby authorize release of my dental records on this date:

_____

From Dr.:

_____

Mailing Address:

_____

Phone Number: Fax Number:

_____

For the following member/s of my family:

_____

To be released to:

Dr. Stephanie R. White 3965 Highway 101 N. Gearhart OR 97138 Ph#:503.738.9273

I also hereby release Dr.:

_____

from any liability related to the disclosure of confidential privileged information.

☐ I hereby release the above named Dr. from any liability related to disclosure of confidential privileged information.

Signature: _____ Date: _____

Response Date: _____