MEDICAL/DENTAL RECORDS RELEASE

TO: _____

_____

_____

I hereby request and authorize you to disclose and release all medical/dental records to the Pediatric Dental Clinic at Bridgeport regarding all information you may have concerning patient:

Patient: _____ DOB: _____

Including, but not limited to any and all office records, office charts, medical/dental charts, hospital records, hospital charts, or any additional records you may have. Please release and forward all medical/dental records to:

Ben Kang, DMD, MS, PC
Pediatric Dental at Bridgeport
7455 SW Findlay Rd
Tigard, OR 97224
(503) 992-6189 FAX (503) 992-6193
Email: contact@brightlittlesmiles.com

A copy of this authorization shall be considered as effective and valid as the original.

Today's date_____

Relationship to the patient_____

Signature_____