

River Mill Dental  
PO Box 929  
Estacada, OR 97023  
(503)630-4218

RiverMillDental@gmail.com

## Authorization to Release Dental Information

Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please Check One:      \_\_\_\_\_ Send to      \_\_\_\_\_ Request from

Dentist: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

### Information Requested:

\_\_\_ Most recent X-rays and patient treatment information

\_\_\_ Most recent full mouth X-rays

\_\_\_ Periodontal Charting

\_\_\_ Other: \_\_\_\_\_

### Reason for Request:

\_\_\_ Change in provider

\_\_\_ For insurance or legal purposes

\_\_\_ For personal use or other: \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature (18 or older must sign for self)

\_\_\_\_\_  
(Date)