Authorization to Transfer Medical/Dental Records

I hereby authorize ______________________________________, to furnish medical/dental information concerning _______________________________ to Oregon Pediatric Dental Care. Any and all information may be released, including, but not limited to, demographic information, all radiographs, treatment plans, and chart notes pertaining to the patient(s) listed above.

By signing I give my authorization for each of the clinics, Oregon Family Orthodontics, Springfield Kids' Dentist and Eugene Kids' Dentist as needed.

Signature: ___________________________________ Date: ___________

Printed Name: ____

Relationship to patient: ____

Springfield Kids' Dentist
scheduling@springfieldkidsdentist.com
Phone: (541) 654-4996
Fax: (541) 790-2338

Eugene Kids Dentist
scheduling@eugenekidsdentist.com
Phone: (541) 844-1667
Fax: (541) 505-8463