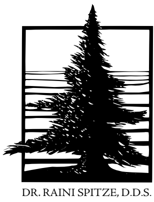

REDLAND
FAMILY
DENTAL
503-631-2353

DR. RAINI SPITZE, D.D.S.

AUTHORIZATION TO RELEASE RECORDS/X-RAYS

Date: ____________

Records Requested From:

Name: ____

Street Address: ____

City: __________________________ State: ____________ Zip: __________________

Phone: (   ) __________________ Fax: (   ) ______________________

I hereby authorize the release of any information relating to my dental, medical and x-rays, on behalf of myself and/or my dependent, to the possession of Redland Family Dental. I further expressly agree and acknowledge that my signature on this document authorizes the above named dentist to release records for services rendered to Redland Family Dental as designated below.

Patient's Name: __________________________________ DOB: _____/_____/______

- ❑ Chart
- ❑ X-Rays
- ❑ Perio Chart
- ❑ Medical History

____ ____________________
Patient/Guardian Signature *Date*

Please Forward Requested Records to:

Redland Family Dental
18221 S. Redland Rd.
Oregon City, OR 97045

(503) 631-2353 office
(503) 631-3253 fax
staff@redlandfamilydental.com