REDLAND
FAMILY DENTAL

DR. RAINI SPITZE, D.D.S.

AUTHORIZATION TO RELEASE RECORDS/X-RAYS

Date:_____

Records Requested From:

Office 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.

□Chart □X-Rays □Perio Chart □Medical History

Patient's Name:_____ DOB:_____

_____ _____
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