

**Request for release of
Dental X-rays and /or Perio Charting**

I, (print patient or guardian name) _____, hereby authorize
_____ to release my dental records to :

Laurelwood | Dental Health
Dental | for a Lifetime

2824 NE Wasco, Suite 210 , Portland, OR 97232

Phone: 503.284.3575 Fax: 503.284.4139

www.laurelwooddental.com

Patient signature: _____ Date: _____

PLEASE FORWARD RECORDS TO: info@laurelwooddental.com