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 :
Laurelwoo Dent	Dental Health al for a Lifetime
2824 NE Wasco, Suite 210 , Portland, OR 97232 Phone: 503.284.3575 Fax: 503.284.4139	
Patient signature:	Date:

PLEASE FORWARD RECORDS TO: info@laurelwooddental.com