Sue Chadwick Walker DMD, PC

2236 SE Washington St., Milwaukie, OR 97222
Phone: 503-659-2522 Fax: 503-659-6022

# AUTHORIZATION TO RELEASE DENTAL INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize: _____ to release dental information of the patient named above to:

Name: Dr. Sue Walker DMD, PC (info@suewalkerdentistry.com)

This request and authorization applies to:
☐ Dental care information relating to the following treatment, condition, or dates: _____

☐ All dental care information including x-rays, perio charting, all treatment rendered and photographs
☐ Other (e.g. models – describe): _____

PURPOSE OF THE RELEASE:

_____Self/Personal Records _____Transfer to another provider _____Attorney/Legal

Other, please explain_____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent. I understand that this authorization will remain in effect until revoked by me in writing.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____