



Authorization to Transfer Medical/Dental Records

I hereby authorize _____, to furnish medical/dental information concerning _____ to Oregon Pediatric Dental Care. Any and all information may be released, including, but not limited to, demographic information, all radiographs, treatment plans, and chart notes pertaining to the patient(s) listed above.

By signing I give my authorization for each of the clinics, Oregon Family Orthodontics, Springfield Kids' Dentist and Eugene Kids' Dentist as needed.

Signature: _____ Date: _____

Printed Name: _____

Relationship to patient: _____

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