NORTHWEST PORTLAND DENTAL

# Patient Records Release Authorization

I _____ hereby request and authorize the office of
(print patient name or guardian name)
Richard Dietrich, D.M.D. to request and receive copies of my x-rays, periodontal records and clinical information concerning my dental care from the folloing office(s):

**Office/ Doctor Name:** _____

**Address:** _____

**Phone Number:** _____

**Please forward records to:** Dr. Richard L. Dietrich
2250 NW Flanders St., Suite 109
Portland, OR 97210

**Digital images and information can be emailed to:** office@NorthwestPortlandDental.com

**Please call with any questions:** (503) 228-6294

Signiture (patient, parent or legal guardian): _____

Date: _____