RECORDS RELEASE REQUEST FOR TREATMENT PURPOSES

Date_____

PATIENT NAME _____

To_____

Address_____

City_____ State_____ Zip_____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

LEINASSAR DENTAL EXCELLENCE
Jeffrey M. Leinassar, DMD, FAGD
1414 Marine Drive, Astoria OR 97103
Phone 503-325-0310 Fax 503-325-1513

_____

Signature of Patient, Parent, Guardian or Personal Representative *Date*

Please Print Signature Name _____

Please Email to
Susan@smileastoria.com
Or
Keely @smileastoria.com