Patient Authorization to Release Confidential Information

I hereby authorize: _____

_____

_____

to disclose and provide copies of any and all clinical treatment records and information concerning my care, which is in the possession of this person or entity, to:

mintie
family dentistry

511 SW 10th Ave, Suite 804, Portland, OR 97205
Phone: 503-243-2505 Fax: 503-243-2967
info@mintiefamilydentistry.com

I understand that the specific type of information to be disclosed includes treatment provided, x-rays and all other records which pertain to me.

Patient: _____ DOB: _____

(Please print)

Signed: _____

(Patient or legal guardian)

Date: _____