AspireDENTAL

Dental Records Release Form

Dr. Lisa Kakishita, DMD
833 SW 11th Avenue, #414
Portland, OR 97205
(p) 503.221.9439 (f) 503.227.5923
aspire@aspiredental.net

Patient Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

Name of Parent/Guardian (if request is for a minor): _____

Select One:

____ I hereby request and authorize my previous dentist: _____,
to release any and all information indicated to Aspire Dental. **Please send x-rays, periodontal probings and most recent treatment plan, if applicable.**
- Previous dentist contact information: _____
- Reason for dental provider change: _____

____ I hereby request and authorize Aspire Dental to release any and all information indicated to:
____Myself
____My new dentist

Information Requested:
( ) X-Rays
( ) Periodontal Probings (Gum Measurements)
( ) Other:

Send Requested Information To:
Name: _____
Address: _____
Phone Number: _____ Fax Number: _____
Email Address: _____

- Reason for dental provider change: _____

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 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.

I understand the Oregon Board of Dentistry regulations require that a dentist provide copies of a patient's records, including x-rays, within 14 days of written request made by the patient or patient's guardian. (OAR 818-012-0030(8)).

I understand that per the Oregon Board of Dentistry, Aspire Dental may require payment in advance that is reasonably calculated to cover the costs of making the copies or duplicates. **Aspire Dental charges a $20 fee if records are needed before the end of the 14 day records request period. Otherwise, Aspire Dental will provide records free of charge by the 14th day of request, at the very latest.** I understand that this is a non-covered service and not reimbursable based upon insurance benefits (if applicable) and is to be paid at the time of records request.

Signature of Patient or Guardian: _____ Date: _____

Office Use Only:

Date Received: _____ 14-Day Due Date: _____

Progress Record:

Dental Records Release Form to be kept in priority file, until records received/sent.