Dental Records Release Consent for
Disclosure of Protected Health Information

____
Dentist/Clinic Name

____
City/State

____
Email address

____ ____________________________________
Phone Number Fax Number

I, ____
authorize the release of all my dental records including but not limited to all chart notes, written records, and radiographic records and for all such records to be sent to:

Christopher Kooning, DMD
Boones Ferry Professional Center
15962 Boones Ferry Road, Suite 105
Lake Oswego, OR 97035
503-675-4594
ckooningdmd@gmail.com

Name of Patient ____

Additional Dependents ____

Signature: ______________________________ Date: ________________________