REQUEST FOR RELEASE OF RECORDS

I _____, hereby request and give my

Permission to Dr. _____ to provide any and all information and copies of my x rays to Mo Biria, DMD. Email if possible, to frontoffice@westlinndental.net. If that is not an

option, please mail films to:

West Linn Dental

19157 Willamette Drive

West Linn, OR 97068

Patient's Name_____

A photograph of this release will be as effective and valid as the original.

Signed: _____ Date:_____

Patient

Signed: _____

Parent, Legal Guardian or Custodian of the patient if patient is a minor

Address: _____

City, State, Zip