

**RELEASE OF INFORMATION**

I HEREBY REQUEST AND AUTHORIZE TO RELEASE THE MOST CURRENT RADIOGRAPHS AND RECORDS OF:

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Address

\_\_\_\_\_  
Other Family Members

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Other Family Members

\_\_\_\_\_  
Date of Birth

PLEASE FORWARD RECORDS TO:

Dr. Patrick A. Sherrard, DMD, PC  
2350 SW Multnomah Blvd.  
Portland, OR 97219  
Phone: 503-246-4712  
Fax: 503-246-0853

BEFORE: \_\_\_\_\_  
Date of Appointment

PLEASE ALSO INCLUDE

\_\_\_\_ LETTERS FROM ANY SPECIALIST  
\_\_\_\_ HISTORY REGARDING TOOTH NO.: \_\_\_\_\_

Each adult must sign as permission to release records for themselves or family members under the age of 18 years; as per Federal Privacy Act.

\_\_\_\_\_  
Signature of Patient or Parent/ Guardian

\_\_\_\_\_  
Date