Patrick Sherrard DMD, PC
your smile, portland-style

503.246.4712
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9053 SW Beaverton-Hillsdale Hwy
Portland, OR 97225

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
9053 SW Beaverton-Hillsdale Hwy
Portland, OR 97225
Phone: 503.246.4712
Email: smile@drsherrard.com

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