GIFFORD
FAMILY DENTISTRY
Gentle • Friendly • Trusted

Record Release Request

Date: ____________________

To: ____

Address: ____

City: ____________________ *State:* ________________ *ZipCode:* ___________________

Telephone: ________________________________ *Fax:* _____________________________________

I authorize the release of dental and medical records relevant to dental treatment, or copies of such and request that they are transferred to:

Dr. Todd A. Gifford
Gifford Family Dentistry
1616 SW Sunset Blvd. Suite E
Portland, Oregon 97239

Telephone: *(503) 246-1710*
Fax: *(866) 339-7503*

Please send digital radiographs and records to:

info@giffordfamilydental.com

Printed Patient Name: ____ **Date of Birth:** __________________________

SIGNATURE OF PATIENT **(or guardian):** ____