Dr. Leslie R. Milfred
1130 SW Morrison Street, Suite 450
Portland OR 97205
503-227-4410
Fax 503-227-6007
office@drmilfred.com

Authorization to Release Patient Records

I hereby request and authorize the release of all dental records and a copy of dental radiographs from the office of Dr. _____ and release him/her from any liability related to disclosure of confidential or privileged information, for the following patients:

_____ DOB_____

_____ DOB_____

_____ DOB_____

Signature _____ Date _____

Relationship to patient_____

If possible, please e-mail radiographs to Dr. Milfred at the following e-mail address:
office@drmilfred.com Thank you!

For office use:

Phone number:_____

Fax number: _____

E-mail: _____

Date requested: _____

Records expected: _____