WILSONVILLE
DENTAL CARE

Records are being requested from:

Office Name & Address: _____

_____

_____

Please release the records for:

Patient Name: _____ Date of Birth: _____

Please forward any of the following information that you have on file: x-rays, perio charting, and photographs to Wilsonville Dental Care.

I hereby give you permission to release my dental records to Wilsonville Dental Care.

Patient/Guardian Signature: _____ Date: _____

Printed Name: _____