Patient Request for Records

Date: _____

(Dentist)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email : _____

Phone Number _____ **Fax:** _____

I hereby authorize the release of my x-rays and/or records and request they be transferred to:

Dr. Brian Allen, DDS

946 NE Burnside Street

Gresham, OR 97030

drallensoffice@gmail.com **Fax: 503-669-8197**

_____ _____

Patient Name (Print) **Patient Name (signature)**