Please complete this form fully and sign it. Once received, we will email records under 25 Mb at no charge to you. CBCT requires a USB as these files are too large to email.

For a USB to be sent instead: send a check back for $5.00 for a small USB for the digital record not to exceed 25Mb. A fee of $30.00 for USB to contain CBCT if one was taken. If you would like your complete record provided to you and your new provider on a USB, please provide the appropriate fee for two USBs with this notice to process your records. Paper copies and certified mail processed at a different rate. Please call and ask.

Please allow 14 days from the date we receive this request signed to process.

Patient Information

Patient Name ____ Other Name Used ____________________________________

Date of Birth ________/_________/__________ Social Security Number ________/__________/_________

Address ______________________________________ City ___________________________ State ________ Zip ______________

Day Phone (_____)________-___________ Evening Phone (____)________-________ Cell Phone (___)_______-_________

*****Please Note: There may be a fee charged for medical and/or dental records.**

FROM

Above patient authorizes the following healthcare facility to make record disclosure:

Facility/Provider Name :

Drake Periodontics & Implantology, PC , 2235 Mission St. SE STE 250, Salem, OR 97302

Phone -503.385.8821~ Fax ~503.385.8825

Specific information to be released:

- ☐ Dental Radiographs from (insert date)_____/____/____ to (insert date) ____/____/____

I approve the release, disclosure, and delivery of general medical/dental reports, history & physicals, progress notes, and diagnostic test reports. Also, immunizations, prenatal records, consultations and any other information necessary for the purpose of treatment by TCCH are approved. Information relating to STD's, HIV/AIDS, TB, Drug/Alcohol, Mental Health, WIC Eligibility & Early Intervention may be included.

The above patient requests the records to be disclosed to:

TO

Name of Facility/Provider/Self :

Street address: **Please Email Records** ☐

City, State, Zip:

Phone: Fax: **Please Fax Records** ☐

I do not give permission for any other use of this information.

This permission will expire one year from the date of my signature. I may cancel this authorization at any time by sending written notice to Drake Periodontics & Implantology.

_________________________________ _____________________ ____________________

Patient/Guardian Signature Relationship Date