Authorization for the Release of Dental Records

I hereby authorize:_____

To release the information in the dental records of:

_____**DOB:**_____

To:

Rick R. Campbell, DDS, PC
2591 NW Kline Street
Roseburg, OR 97471
Phone 541-672-4732
Fax 541-677-9017

Any and all information may be released including but not limited to:
**All treatment notes
**All x-rays
**Other information regarding dental history, diagnosis and treatment

Reason for transfer_____

Please send records at your earliest Convenience

This Authorization is effective now and will remain effective for 90 days after the date indicated below. I understand that I may receive a copy of this authorization. I further understand that some offices may charge a fee to cover the cost of the transfer.

_____ _____
Signature Date

DIGITAL OFFICES, PLEASE E-MAIL X-RAYS TO : lori@roseburgdentist.com