Authorization to Release Dental Records

I hereby authorize and request Dr.________________________________ to release all X-Rays within the last 5 years and any pertinent chart notes to:

❑ **American Dental**
2530 NW Medical Park Drive
Roseburg, Oregon 97471

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Patient's Signature (or legal guardian) Date

Additional Family Members:

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For Electronic Submission: I do hereby acknowledge that this transaction is being conducted by electronic means and by typing my name herein below or transmitting this document to American Dental, I am subscribing to this agreement and thereby providing my electronic signature. By typing my name in the space below or by the act of transmitting this document to American Dental, I intend to be bound by the terms and conditions of the doctor-patient agreement herein and the terms and conditions therein are in full force and effect and legally enforceable against me.