Records Release Form

I _____ request the release of dental records relevant to dental treatment, or copies of such, and request they be transferred TO/FROM the office of:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Email: _____

And transferred TO/FROM the office of:

Newberg Kids' Dentist
Dr. Navid Newport DDS
2502 Portland Rd
Newberg, OR 97132
Ph 503.538.4289
Fx 503.538.4352
smile@newbergkidsdentist.com

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Records being requested:

( ) Current radiographs	( ) Dental Health Status	( ) Reports
( ) Diagnostic Casts	( ) Treatment Plan	( ) Charts
( ) Health History	( ) Prescription Records	( ) Photos

Signature of Parent/Guardian: _____ Date: _____