



**EAST MAIN
DENTAL
CENTER, LLP**

RANDY D. WOOTON, D.M.D.
GREGORY L. PEARSON, D.M.D.
HAL L. BORG, D.M.D.
CALIE ROA, D.M.D.
ERIC N. ALSTON, D.M.D.

1123 East Main Street, Medford, Oregon 97504
Telephone (541) 773-3422

Patient Authorization – Request for Release of Records

To (*Dentist's name*): _____

Street address: _____

City/State/Zip: _____

I hereby authorize you to release the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be used or disclosed:

All Films within the last 5 years
Periodontal Charting
Last Hygiene Appointment date: _____
What type of cleaning was done at that time? _____
Has root planing been completed? If so, what dates and quadrants? _____

Person or entity requesting the information and authorized to make the requested use or disclosure:

Email information to: tonya@eastmaindentalcenter.com or

Mail information to: EAST MAIN DENTAL CENTER, LLP
1123 East Main Street
Medford, OR 97504

This information is being requested for the following purpose(s):

Patient Name: _____

Signature: _____

Relationship to Patient (if signed by personal representative of Patient): _____

Date: _____