East Main Dental Center, LLP

GREGORY L. PEARSON, DMD
HAL L. BORG, DMD
KENNETH D. McGOWAN, DMD
IAN KITTELSON, DMD

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: info@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: _____

11/10