BROADWAY DENTAL CARE

2606 NE Broadway, Suite A
Portland, Oregon 97232
(503)595-KIND (5463)

AUTHORIZATION FOR RELEASE OF IDENTIFYING DENTAL RECORDS

Patient Name: _____
Patient Address: _____
Patient Phone Number: _____
I authorize Dr._____ Phone:_____to release a copy of my full set of x-rays to:

Broadway Dental Care
2606 NE Broadway, Suite A
Portland, Oregon 97232
503-595-5463
broadwaydentalcare@comcast.net

Office please include dates for last:
FMX:_____
BWS:_____
Exam:_____
Last Cleaning Date:_____

The office is equipped to receive electronic copies via email, if possible please email x-rays to: broadwaydentalcare@comcast.net

I agree to have my record released to Broadway Dental Care so that they maybe used for further dental treatment.

Patient Signature: _____ Date: _____
Printed Name: _____