Portland Community College®

PCC Dental Clinic
Vanport Building - 3rd Floor
1810 SW 5th Ave
Portland, OR 97201

Dental Records Release Form

PCC Dental Clinic - Consent to Release Records Digitally

Patient Name:_____ Today's Date:_____

Date of Birth:_____ Phone Number:_____

I hereby request and authorize: _____

to provide copies of my records to:

____Myself. Email:_____

____OHSU Dental Clinic

____Other Dental Office Name & Email: _____

_____

____I have an upcoming appointment, and need records sent by:_____

The Records I am asking to be transferred are:

____X-Rays

____Chart Notes

____Other (Please Specify) _____

By signing this form, I expressly release the person transmitting my records and PCC from any and all liability arising from compliance with this request and disclosure of the requested information.

_____

Patient Signature & Date