



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 PCC Dental Clinic 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: _____ (date)

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

For Office Use Only. Release completed By: _____ Date: _____

Patient # _____