RIVERPLACE
PERIODONTICS

RELEASE OF RECORDS REQUEST

I, the undersigned, grant permission to Dr. _____
to release x-rays, intra oral photos or pertinent information requested to:

Duy Anh Tran, DMD
Sarah Nguyen, DMD

Riverplace Periodontics
2636 SE Harrison Street, Suite A
Milwaukie, OR 97222
Office: 503-654-5405
Fax: 503-654-5406
Email: info@riverplaceperio.com (Preferred method)

Patient Name: _____

Patient Address: _____

Patient Birthdate: _____

Parent Signature (if under 18 yrs) _____

Patient or Guardian Signature: _____

Date: _____