Soft Touch Dental, P.C.

Request for Release of Records

I, _____, hereby request and give my permission to Soft Touch Dental, P.C., to provide _____ _____Email_____ any and all information he/she requests with respect to the dental treatment of _____

(Patients Name)

We can provide these records through the US Mail. The fee for duplication of records is $25, this fee is required prior to the duplication. If you choose to have ONLY your x-rays emailed, there is no fee. A copy of this release will be as effective and valid as the original.

Signed_____ Date_____
(Patient)

Signed_____ Date_____
(Parent/Legal Guardian/Custodian/Representative)

Address_____

Portland
1727 NE 13th Ave
Portland, OR 97212
O:503-249-1100
F:503-249-2969

Tualatin
18773 SW Martinazzi Ave
Tualatin, OR 97062
O:503-692-9280
F:503-612-9195

Gresham
907 NE 2nd St
Gresham, OR 97030
O:503-465-0005
F:503-465-0001

Springfield
1403 F St
Springfield, OR 97477
O:541-746-5555
F:541-746-7062

Clackamas
11808 SE Sunnyside Rd
Clackamas, OR 97015
O:503-698-1112
F:503-698-1119

Woodburn
967 N Cascade Dr.
Woodburn, OR 97071
O:503-981-6133
F:503981-4143