Theresa Lindquist, DMD

1296 Commercial St. SE
Salem, OR 97302
503.585.4282
FAX: 503.375.9534
EMAIL: pearlywhitesfamilydentistry@gmail.com

Authorization for Release of Dental Records and X-rays

I, ____ (print patient/guardian name), hereby authorize the doctors and staff at ______________________________to release records or knowledge concerning my dental health to: ____________________________.

Full Dr. Name: ____

Street Address: ____

City, Zip Code: ____

Phone Number: ____

I specifically request that you release copies of:

☐ all x-rays ☐ all treatment notes

Patient name ____

Signature ____