# Record Release Request

GIFFORD
FAMILY DENTISTRY
GENTLE • FRIENDLY • TRUSTED

## Record Release Request

Date: * 06/18/2025

Previous Dental Office: *

Address *

City * Portland

State * OR

Zip Code * _____

Telephone: (___) ___ - ____

Fax:

***I authorize the release of dental and medical records relevant to dental treatment, or copies of such and request that they are transferred to:***

***Dr. Todd A. Gifford***
***Gifford Family Dentistry***
***1616 SW Sunset Blvd. Suite E***
***Portland, Oregon 97239***

***Telephone: (503) 246-1710***
***Fax: (866) 339-7503***

***Please send digital radiographs and records to: info@giffordfamilydental.com***

Patient's First Name *

Patient's Last Name *

Date of Birth * __/__/____

Signature of Patient (or guardian) *