Authorization to Release Patient Records

Michael B Litchfield DMD

1520 Commercial St SE

Salem, Oregon 97302

Phone: 503-364-7244

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Email: drlitch@hotmail.com

Previous Dentist:_____

I, _____, hereby authorize and request the release

Of my records to :

Michael B Litchfield DMD

1520 Commercial St SE

Salem, Oregon 97302

Please include all chart notes and current xrays including FMX OR PANOREX.

Date of last cleaning: _____.

Signature_____