

****Please allow 3-5 business days for processing****

Pediatric Dental at Bridgeport

Dentistry for Infants, Children & Teens

Ben Kang DMD, MS, PC

MEDICAL/DENTAL RECORDS RELEASE

TO: _____

I hereby request and authorize you to disclose and release all medical/dental records to the Pediatric Dental Clinic at Bridgeport regarding all information you may have concerning patient:

Patient: _____ DOB: _____

Including, but not limited to any and all office records, office charts, medical/dental charts, hospital records, hospital charts, or any additional records you may have.

Please release and forward all medical/dental records to:

Ben Kang, DMD, MS, PC
Pediatric Dental at Bridgeport
7455 SW Findlay Rd
Tigard, OR 97224
(503) 992-6189 FAX (503) 992-6193

A copy of this authorization shall be considered as effective and valid as the original.

Today's date _____

Relationship to the patient _____

Signature _____