James A Miller DMD

Consent for Release of Dental Records

T (503) 640-9310 F (503) 648-3794

Patient(s) Name: _____

Date: _____

To Whom It May Concern:

I authorize you to provide to Dr. Miller any and all information with respect to my dental treatment or the dental treatment of my family as listed below. A photograph of this release will be as effective and valid as the original.

Please release my complete chart including chart notes & dental x-rays to Dr. James A. Miller.

If digital radiographs are available, please email to:
office@drjamesamiller.com

Otherwise, please mail to:
Dr. James A Miller, DMD, PC
518 S.E. Oak Street, Suite 100
Hillsboro, OR 97123

Thank you,

_____
Signature of Patient or Patient's Legal Representative

Doctor records are being requested from:

Name:_____

City/State of Practice:_____

Phone/Fax:_____ _____