CHEHALEM **DENTAL**

Name: ____

RECORD TRANSFERS FORM

Birthdate: ______________________________________

To: (Doctor or clinic): ____

Phone: ______________________________________ Fax: ____

I hereby authorize the release of my records including treatment notes, radiographs, clinical photographs, and CBCT scans and request that they be transferred to:

Chehalem Dental
902 Deborah Road
Newberg, OR 97132-2001

Phone: (503) 538-3129
Fax: (503) 528-3120
Email: info@chehalemdental.com

Patient / Guardian Signature: ____ Date: _______________