



Records Transfer Form

I hereby request and authorize you to disclose and provide copies of any and all clinical treatment records and information concerning my care to:

Gorge Dental  
405 13<sup>th</sup> St  
Hood River, OR 97031  
P: 541-387-2244  
F: 541-387-2243  
E: [office@gorgedental.com](mailto:office@gorgedental.com)

These records include but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models, and other related materials.

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Patient Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_