SELECT CARE DENTAL Redmond

Patient Consent to Release Records

I, _____, give my consent for the office of _____ to release my dental radiographs and dental records that may include HIPAA's Special Protections (HIV/Aids, Mental Health, Genetic, and substance use disorder information) to Dr. Jared R. Anderson and Mark T. Nuttall.

Name of Patient:

DOB:

Address:

Telephone #:

_____ _____
Patient's Signature Date

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative Name: _____

Relationship to patient: _____

Date consent sent: _____

Authorized representative of the Select Care Dental Team:_____

Please email records to office.selectcare@gmail.com
774 SW Rimrock Way Redmond, OR 97756
Phone (541) 923-7633 Fax (541) 923-8733