SHAC Dental Services
Portland State University
Phone: 503.725.2611
Fax: 503.725.2620
527 SW Hall St. Portland, OR UCB Suite 309

Authorization to Release Dental Information

Patient Information

Patient Name: _____ Date of birth: _____/_____/_____

PSU ID Number: _____

Send to or Request From

Dentist/Office: _____

Address: _____ City: _____ State:_____

Zip:_____ Phone: _____ Fax: _____

Email Address: _____

Information Requested

Information being requested: (check all that apply)

☐ Most Recent X-rays ☐ Other: _____

☐ Periodontal Charting

Reason for Request

Reason for requesting the information: (check all that apply)

☐ Referral to an Outside Provider ☐ Personal Use/Other: _____

☐ Change in Dental Provider

Information Acknowledgement

The above information is authorization to release my records as indicated. This release of information authorization is valid for six (6) months and may be revoked at any time. I also understand that I will be charged an $11.00 fee for releasing my records.

Patient Signature (Required): _____ Date: _____

Pick up_____or Mail_____