Rhett M. Tipton, DMD
271 SW 13th St.
Ontario, OR 97914
(541) 889-7017
Fax: 541-889-6551

Records Transfer Request

Date:_____

Patient's full name:_____ DOB:_____

I hereby authorize Rhett M. Tipton, DMD to (circle) **obtain from** or **release to:**

Dental Office: _____

_____

_____

Please forward all current radiographs (x-rays) and periodontal charting or any other information that would be pertinent to treating the patient.

Medical information is protected under law and will not be released without written consent. Information released with this authorization will not be given, sold, transferred or in any way relayed to any other person not specified above.

The consent will expire one year from the above date unless otherwise specified.

_____ _____
Signature of Patient / Responsible Party Date

P.K. Warner 11-7-16
Witness Date

*** **Please e-mail x-rays to: patty@rhettmtiptondmd.com**