Patient Release Form

I, _____ hereby request and authorize _____

_____ to disclose and provide copies of any and all radiographs and information concerning my care, which is in the possession of this entity, to:

Bull Mountain
FAMILY DENTISTRY

Bull Mountain Family Dentistry
15885 SW 116th Avenue
Tigard, OR 97224
Phone: 503.639.5025
Fax: 503.684.1391
info@bullmountainfamilydentistry.com

Signed: _____ Date: _____