Request to transfer protected health information

The patient below is requesting the transfer of their protected health information to Willamette Dental Group, P.C. Please complete the form below and send along with the requested information. Thank you!

- ❑ X-Rays
- ❑ Chart Notes
- ❑ Perio Probing

Patient Information		
Name:		
DOB:		
Address:		
City:	State:	Zip:

From:			**To:**		
❑ Dr. Name:			Willamette Dental Group, P.C.		
Company:			Please submit completed form to adminrecords@willamettedental.com via Willamette Dental's secure email.		
Address:			Instructions on how to use our secure email can be found at wdglink.com/secure-email-instructions		
City:	State:	Zip:	6950 NE Campus Way		
Phone:		Fax:	Hillsboro	OR	97124
Email:			Phone: 1-855-433-6825		

I authorize _____ to duplicate, use or disclose my protected health information as described above. Authorization will expire in 90 days unless I revoke it earlier by written request. The patient/member, parent or authorized personal representative must sign this authorization.

_____ _____

Signature of Patient, Parent or Authorized Representative Date