AspireDENTAL

Dental Records Release Form

Dr. Lisa Kakishita, DMD
●511 SW 10th Avenue, #902 Portland, OR 97205 ●PH:503.221.9439 ● smile@aspiredentalpdx.com

Patient Name: _____ **Date of Birth:** _____
Address: _____ **Phone Number:** _____
Name of Parent/Guardian (if requesting for a minor): _____

Select One:

____ **I hereby request and authorize my previous dentist to release all information indicated to Aspire Dental:**
Please e-mail: all x-rays, periodontal probings, and treatment plan to: smile@aspiredentalpdx.com
Previous dentist contact information: _____
Reason for dental provider change: _____

____ I hereby request and authorize Aspire Dental to release all information indicated to:
____ My new dentist ____ Myself

Information Requested:
( ) X-Rays ( ) Periodontal Probings ( ) Gum Measurements ( ) Other:

Reason for dental provider change: _____

Send Requested Information To:
Name: _____
Address: _____
Phone Number: _____ Fax: _____
Email Address: _____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent.

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action had been taken which was based on my consent, I may withdraw this consent at any time by submitting my request in writing.

I understand the Oregon Board of Dentistry regulations require that a dentist provide copies of a patient's records, including x-rays, within 14 days of written request by the patient or patient's guardian. (OAR 818-012-0030(8)).

I understand that per the Oregon Board of Dentistry, Aspire Dental may require payment in advance that is reasonably calculated to cover the costs of making the copies or duplicates. **Aspire Dental charges a $20 fee if records are needed before the end of the 14-day records request period. Otherwise, Aspire Dental will provide records free of charge by the 14th day of request, at the very latest.** I understand that this is a non-covered service and not reimbursable based upon insurance benefits (if applicable) and is to be paid at the time of records request.

Signature of Patient/Guardian: _____ **Date:** _____

Office Use Only

Date Received: _____ 14-Day Due Date: _____

Progress Record:

Records Release Form to be kept in priority file, until records received/sent