Dental Records Release

Patient Name: ___________________________
Date of Birth: __________
Phone number: __________________

All Family Members: Y / N

Dentist: ____________________________________
Address: ___________________________________
Phone number: ___________________
Email/Fax : __________________________

Please forward any of the following information that you have: patient notes, x rays, charting, intra oral photos to:

Dr. Kenneth Winokur DMD
winokurdental@aspidamail.com

I hereby give you permission to release any Dental records to the above Dentist.

Patient Signature: _____________________ Date: __________

Dr. Kenneth Winokur DMD
Independence Dental
329 S Main St
Independence, OR 97351
P: 503/838-1633
F: 503/838-4640