



Pediatric Dentistry

11790 SW Barnes Rd, Suite 280

Portland, OR 97225

P 503-626-9700 F 503-626-9772

info@visitworldofsmiles.com

Release of Records

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

From Prior Office to World of Smiles, Pediatric Dentistry

I authorize transfer of all records, including financial and x-ray information to World of Smiles, Pediatric Dentistry for the above named child(ren).

Parent Name (printed) _____

Parent Name (signature) _____ Date: _____

Office Only Received records date: _____ Initial: _____

From World of Smiles, Pediatric Dentistry to New Office

I authorize transfer of all records, including financial and x-ray information from World of Smiles, Pediatric Dentistry to:

*Office Name _____

*Phone # _____

*Email _____

*Required information. Please note that all patient records are electronic in nature. We must be able to transfer digital films via email.

Parent Name (printed) _____

Parent Name (signature) _____ Date: _____

Office Only Sent records date: _____ Initial: _____