Odessa Dental Clinic
Gregg Liedtka DMD PLLC
PO Box 429 Odessa WA 99159
Phone: (509) 982-2605, Fax: (509) 982-9951
Email: Odesssadentalclinic@gmail.com

Authorization to Release Patient Information

This authorization expires 90 days from the date it is signed

Dr. Name_____
City _____State_____
Phone _____Fax _____Email_____

I, _____,
(patient/parent/guardian, print)

Give the **above** named dental/medical facility permission to release records to:
Odessa Dental Clinic

_____ Date _____
(patient/parent/guardian signature)

Please review your records and send any information that may be of assistance in treating this patient. Thank you for your time and cooperation.

_____
Patient Name (print) ***Date of Birth***

Recare Dates: Exam _____ Prophy _____ SRP _____

X-Ray Dates: FMX _____ BWX _____ Pano _____

Please Send copies of Bitewings less then two years old and FMX or Pano less than five years old. Thank You.

Date of Request: _____