Lindsay Freed Brown, DMD
Randall N. Freed, DMD, FAGD

Records Transfer Request

Authorization to Release Dental Records:

Patient Name:

Date of Birth:

Please send my records to:

Dr. Lindsay Freed Brown, DMD
12889 NW Cornell Rd
Portland Or, 97229
Phone: 503-643-6643
Fax: 503-644-5972
Email records to: Info@LFBDMD.com

I do hereby give permission to release a copy my dental records to Dr. Lindsay Freed Brown, DMD

_____ _____
(Signature of patient *or* parent/guardian) (Date)