

Request to Transfer Protected Health Information

The patient below is requesting the transfer of their protected health information to Willamette Dental Group, P.C. Please complete the form below and send along with the requested information. Thank you!

- X-Rays
- Chart Notes
- Perio Probing

Patient Information		
Name:		
DOB:		
Address:		
City:	State:	Zip:

From:		To:	
<input type="checkbox"/> Dr.	Name:	Willamette Dental Group, P.C.	
Company:		Please submit completed form to records@willamettedental.com via Willamette Dental Group's secure email.	
Address:		Instructions on how to use our secure email can be downloaded from https://willamettedental.com/secure_email_instructions.pdf	
City:	State:	Zip:	6950 NE Campus Way
Phone:	Fax:	Hillsboro	OR 97124
Email:		Phone: 1-855-433-6825	

I authorize _____ to duplicate, use or disclose my protected health information as described above. Authorization will expire in 90 days unless I revoke it earlier by written request. The patient/member, parent or authorized personal representative must sign this Authorization.

Signature

Date