

 Kathryn E. Nicholson, D.M.D., P.C.

2650 Washburn Way, Suite 240 - Klamath Falls, Oregon 97601 - (541)885-5578

Patient Authorization to Release Confidential Information

I, _____, hereby authorize you to disclose and provide copies of any and all clinical treatment records and information concerning my care, which are in your possession to:

Name: _____
Street address _____
City: _____ Zip Code: _____
Office Phone Number: _____

These records include, but are not limited to : Personal Patient Information, Medical and Dental History, Examination Records, Treatment Records, Referral and Consultation Recommendations, Diagnostic Models, and other Related materials.

Please send x-rays and information to :

Kathryn E. Nicholson, DMD, PC
2650 Washburn Way STE 240
Klamath Falls, OR 97601

Signature: _____



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I understand a fee of \$15.00 will be charged for duplication and mailing of current radiographs (x-rays). Upon receipt of this fee the x-rays will be transferred within 14 working days.

The fee may be paid by check or credit card to:

Kathryn E. Nicholson, DMD, PC
2650 Washburn Way STE 240
Klamath Falls, OR 97601

Credit card Number: _____ Exp: _____
Card Holder: _____
Mailing Address of Card: _____

Signature: _____ Date: _____
(Patient or Responsible Party)