Starley Family Dentistry
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520 15TH STREET • ASTORIA, OR 97103
(503)325-6662

RELEASE OF RECORDS TO STARLEY FAMILY DENTISTRY

Patient Name:

Last First MI

Preferred Name

I plan to see Dr. Starley on this date:

I hereby authorize the release of my dental records From Dr.:

Mailing Address / City / State / Zip

Phone Number: Fax Number: Email:

For the following member(s) of my family:

To be released to: Dr. Matt Starley / 520 15th Street / Astoria, OR 97103 / Fax: (503) 325-0637 / Email: Office@StarleyFamilyDentistry.com

☐ * **I hereby release the above name doctor from any liability related to the disclosure of confidential privileged information.**

Patient/Guardian Signature:

Response Date: