



## RELEASE OF INFORMATION

Name of Patient \_\_\_\_\_ DOB: \_\_\_\_\_

*I hereby authorize College Hill Dental to disclose records  
Obtained in the Course of my dental diagnosis and treatment to:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I understand that the requester may not further disclose the information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*If other than patient please indicate relationship:* \_\_\_\_\_

[Office@collegehillsmiles.com](mailto:Office@collegehillsmiles.com)

2400 Willamette Street

Eugene, Oregon 97405

P: 541-485-0272

F: 541-485-0139



## RELEASE OF INFORMATION

Name of Patient \_\_\_\_\_ DOB: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ to disclose records

Obtained in the Course of my dental diagnosis and treatment to:

*College Hill Dental*

*Dr. Ivan Paskalev DMD*

*Family Dentistry*

*I understand that the requester may not further disclose the information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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