# Thomas R. Rheuben, DMD, LLC
# Maureen N. Porter, DDS

# RECORDS RELEASE

**To the office of Dr. _____**

**The following patient:_____**

**Has requested that their records and films be sent to our office at the address listed below.**

**This information is strictly confidential and will not be released without the written consent of the patient of guardian, in accordance with HIPPA regulations.**

**Please release these records at your earliest convenience.**

**Thank you!**

**Patient or Guardian Signature_____**

**Date _____**

**304 W Adams, PO Box 2211, Sisters, OR 97759**
**Phone 541-549-0109 Fax 541-549-6915**
**drrheuben@gmail.com**