I hereby authorize the office of Dr. _____
To release my protected health information in the form or written and/or radiographic records to:

Dr. Thomas Rheuben, DMD, LLC
P.O. Box 2211 - 304 W Adams
Sisters, OR 97759
Ph 541-549-0109 Fax 541-549-6915
Email - drrheuben@gmail.com

Patient Name _____

Patient Signature _____

Date _____