Authorization to Release Dental Records

Patient's Name _____

I request and authorize _____ to release dental information and records for the above named patient to:

Name _____

Address _____

City, State, Zip _____

Phone Number _____

Please include:

X-rays (full mouth and/or Pano within the last 5 years)
Perio Charting

Signature _____

Date _____

Email digital X-rays and electronic Perio charts to: carol@vancouverdds.com

Thurston Oaks Dental
4305 NE Thurston Way, Suite A, Vancouver, WA 98662
Phone: (360) 514-9212 | Fax: (360) 514-9214
www.vancouverdds.com