Pacific Oak Dental

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Authorization to Release Dental Records

I, ____ Date of birth _____/______/_________
herby authorize the release of my dental records and/or that of my dependents.

Doctor/Clinic: ____
Address: ____
Phone #: _______________________
Fax #: _______________________

Please include:

- Full mouth series, panoramic, bitewings, and or periapical radiographs
- Periodontal charting for patients with history of periodontal disease
- Dates scaling and root planing were completed if applicable
- Dates of the last cleaning and exam

Please send my records to:
Pacific Oak Dental
1951 Oak Street Suite A
Forest Grove, OR 97116
(503) 357-9122
info@pacificoakdental.com

Release records for the following dependents:

Name ______________________________________ Date of Birth ______/______/______
Name ______________________________________ Date of Birth ______/______/______
Name ______________________________________ Date of Birth ______/______/______

Signature ____Date ______/______/______