

Pacific Oak Dental

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Forest Grove, OR 97116

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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 ____/____/____