Authorization for release of dental records and dental radiographs

Patient Name:_____

I hereby authorize the doctor and staff to release records or knowledge concerning my dental health to:

Pickens Family Dentistry
Dr. Drue Pickens DDS
7508 NE Vancouver Mall Dr.
Vancouver, WA 98662
P. 360.254.6411
F. 360.944.5952

Email digital x-rays and electronic perio charts to: info@pickensdds.com

Please include full mouth and/or pano, most recent bitewing x-rays, and perio charting.

Please forward the appropriate records or radiographs so they will be available for my appointment on _____. If this is not possible, please contact the patient or Pickens Family Dentistry before the above date.

Signature:_____
(Patient, Parent or Guardian signature)

Date:_____