PATIENTS OF RECORD AUTHORIZATION TO RELEASE RECORDS

BRETT L. JOHNSON D.M.D
601 MONROE STREET
OREGON CITY, OREGON 97045
503-656-1522
503-722-7978 fax
info@oregoncitydentistry.com

DATE: ______________________

I, ____ Date of Birth ____________________

Authorize the release of my dental records and x-rays to be sent to the office listed below:
I understand that only current x-rays will be transferred, as well as a copy of my current periodontal probing (if requested).

To be released to:

NAME: ____

ADDRESS: ____

CITY: _________________________________ STATE: ______ ZIP ________________

EMAIL: _____________________________ PHONE: ____________________________

FAX #: ______________________________

Please list any dependents for which you would also like records transferred:

____ DATE OF BIRTH __________________

____ DATE OF BIRTH __________________
(If family member is a spouse or 18 years of age or older, they must sign their own records release.)

Signature: ____