NEW PATIENT RECORDS RELEASE

DATE: _____

I, _____ Date of Birth _____

Authorize the release of my dental records and x-rays to be sent to the office of:

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

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 FROM:

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: _____