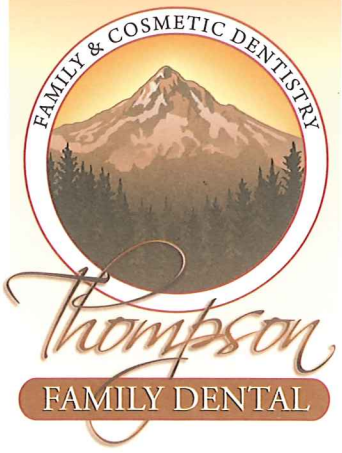

AUTHORIZATION TO RELEASE DENTAL INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

PREVIOUS DENTIST INFORMATION:

DENTIST NAME: _____

DENTIST PHONE: _____

INFORMATION REQUESTED:

__X__ MOST RECENT X-RAYS

__X__ MOST RECENT FULL MOUTH SERIES X-RAYS

__X__ PERIODONTAL CHARTING

REASON FOR REQUEST:

☐ CHANGE IN DENTAL PROVIDER

☐ FOR INSURANCE OR LEGAL PURPOSES

☐ FOR PERSONAL USE OR OTHER: _____

The above named is authorized to release my records as indicated. This release of information authorization is valid for six (6) months and may be revoked at any time. I understand Thompson Family Dental reserves the right to charge a fee for duplicating records.

X: _____ _____

Patient Signature (if age 18 or older must sign for self) Date

X: _____ _____

Parent / Guardian Signature (if applicable) Date

(Email records to: Noelle@ThompsonFamilyDental.com)

OUR SERVICES

Cleanings and exams

Tooth colored fillings & crowns

Dentures

Root canal therapy

Routine Extractions

Dental Implants

Ernest R. Thompson, D.M.D. P.C.
3895 SW 185th Avenue, Suite 130 • Aloha, Oregon 97078 • (503) 649-5900 • fax (503) 649-9047
www.thompsonfamilydental.com