AUTHORIZATION TO RELEASE DENTAL INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

PREVIOUS DENTIST INFORMATION:

DENTIST NAME: _____
DENTIST PHONE: _____
DENTIST FAX: _____

INFORMATION REQUESTED:

_____ MOST RECENT X-RAYS

_____ MOST RECENT FULL MOUTH SERIES

_____ 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 Slater & Nevills Family Dentistry reserves the right to charge a fee for duplicating records.

X: _____ _____
Patients Signature (if age 18 or older must sign for self) Date

X: _____ _____
Parent/Guardian Signature (if applicable) Date

(Email records to: frontdesk@slaterfamilydental.com)

Jay M Slater, D.M.D. / David E Nevills, D.M.D.
18540 SW Vincent St., Aloha, OR 97078 / (503) 649-5900 / fax (503) 649-9047
www.slaterfamilydental.com