Distinctive Dentistry

Authorization to Release Dental Information

The execution of this form does not authorize the release of information other than that specifically described below.

Release From: (Current Dentist)
Noelle M. George, DMD LLC
13110 SE Sunnyside Rd. Clackamas, OR 97015
Phone: (503) 698-4884 Fax: (503) 698-6601
Email: office@clackamasdentist.com

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency or individual named in this request.

Release To: _____

Address: _____

Phone:_____ Fax:_____ Email: _____

Patient Name: _____DOB:_____

Patient Name: _____DOB:_____

Patient Name: _____DOB:_____

Information requested:

_____ Copy of Complete Dental Chart _____ Copy of Dental Radiographs

_____ other (models, etc.) Describe: _____

Purpose or need for which information is to be used:

_____ Transfer of records _____ Second Opinion _____ Other

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

_____ _____
Signature of Patient or Guardian Date

distinctive DENTISTRY
dr. noelle george

1/2021