Distinctive Dentistry

Beautiful Smiles for Life

AUTHORIZATION TO RELEASE RECORDS

Patient Name: ____ DOB: ____________________________

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

To: ____

Address: ____

Phone:______________________________ Fax:__________________________

Email:____

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: **Noelle M. George, DMD LLC**
Address: **13110 SE Sunnyside Rd. Clackamas, OR 97015**
Phone: **503-698-4884** **Fax: 503-698-6601** **email: office@clackamasdentist.com**

Information requested:

______ Copy of Dental X-rays

______ Copy of Complete Dental Chart

______ other (models, etc.) Describe: ____

Purpose/need for which information is to be use:

_______ 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

1/2021