



LAKE GROVE DENTAL
PROGRESSIVE DENTAL CARE SINCE 1960

Authorization for Dental Records Release

Patient Information

Patient's Legal Name: _____ Date of Birth: _____

Email: _____ Mobile Ph: _____

Authorization

I request and authorize (doctor or clinic name) _____ to release health and dental care information for the above-named patient to: Charles Branen, DMD, PC (d.b.a. Lake Grove Dental)

Please transfer any the following records applicable:

Panorex, CBCT or Full Mouth X-rays that are under 5 years

Bitewing X-rays under 1 year

Dates & quadrants scaling & root planning were performed

Most recent periodontal charting

Date & type of most recent dental cleaning

A copy of this release will be as effective and valid as the original form. This request and authorization is valid for one year from the date it is signed.

If no images are being sent, please return above information via fax to 503.636.3641

Images and any other info may be emailed to info@lakegrovedental.com

Patient Signature: _____ Date signed: _____

OR Signature of legal Guardian/Parent if a child is under 18 years: _____

4055 Mercantile Dr., Suite 105 | Lake Oswego, OR 97035
Phone/FAX/Text: 503.636.3641 | info@lakegrovedental.com | www.lakegrovedental.com