Release of Information

Date:____________________

I hereby request and authorize____
(Name of Previous Dental Office)

to release the most current **FMX, BWX**, **Perio Chart** and **Records** of:

____ __________________________
(Name of Patient) (Date of Birth)

____ __________________________
(Other Family Members) (Date of Birth)

to Levison Dental Group prior to _________________________.
(Date of Appointment)

Please forward Records to:

Levison Dental Group
9 Monroe Parkway
Suite 130
Lake Oswego, OR 97035
Phone 503 303-4695
Fax 503 303-4971
Email info@LevisonDental.com

Please include any letters from specialists and history regarding tooth #____________.

____
(Signature of Patient, Parent, or Guardian)

____
(Each Adult must sign permission to forward records for self as per Federal Privacy Act)