

# Release of Records

I, \_\_\_\_\_, DOB \_\_\_\_\_, hereby authorize the release of my current PANO/FMX, Bitewings, Perio chart, and important chart notes and request that they be transferred to **Oregon City Family Dentistry** or to my new office listed below.

I am transferring my care to Oregon City Family Dentistry \_\_\_\_\_

I am transferring my care to a new office listed below \_\_\_\_\_

## Previous Dental Office/New Dental Office:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Fax: \_\_\_\_\_

## Family Members (For children under 18. For age 18+ please complete separate form)

_____	DOB _____
_____	DOB _____
_____	DOB _____
_____	DOB _____

### \*\*For incoming records:

## PLEASE SEND SECURE EMAIL OF RECORDS TO

[info@ocfamilydentistry.net](mailto:info@ocfamilydentistry.net) \*\*

\*Please email BWX taken within the last 1yr

\*Please email FMX/PANO taken within the last 5yrs

\*Please email perio charting documented within the last 2yrs

\*Please indicate: Prophy patient \_\_\_\_\_ Perio Maintenance \_\_\_\_\_

\*Dates of SRP (if applicable): \_\_\_\_\_

\*Crown history within the last 10yrs \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Parent or Legal Guardian of minor patient)

**THANK YOU!!**

*This message is intended only for the use of the addressee and may contain information that is privileged and confidential. If you are not the intended recipient, you are hereby notified that dissemination of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by phone.*