_____
Previous Dentist/Dental Office

_____
Mailing Address

_____
City, State, Zip

_____ _____
Phone # ***Fax #***

Patient Name: _____

Patient Date of Birth: _____

Please send the Following:

- ☐ Bitewing X-rays (If less than 1yr old)
- ☐ Pano/Full Mouth X-rays (If less than 5 years old)
- ☐ Periodontal Charting
- ☐ Dates of RPC (if applies) _____
- ☐ Last Date of Cleaning _____
- ☐ Treatment Findings

I hereby authorize the release of dental records for the above-mentioned patient to:

Troy Family Dental
JD Troy D.D.S., P.L.L.C
1118 Ocean Beach Hwy.
Longview, WA

Email: frontdesk@troyfamilydental.net

Your Name: _____ **Relation to Patient:** _____

Signature: _____ **Date:** _____

Authorization Expires 90 days from date signature is acquired.