



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
- Permission to send chart notes upon request

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.