AUTHORIZATION TO RELEASE DENTAL INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below.

To (Current Dentist): ____

Address: ____

____

Phone:_______________________ Fax:_______________________

Email:____

I request and authorize the above named doctor or health care provider to release the information specified below to the organization, agency or individual named in this request.

Release To: H. Alexander Go, DMD
Peterkort Centre One
9555 SW Barnes Rd., Suite 355
Portland, OR 97225
(503) 296-0053 Fax: (503) 297-2057

Patient:____

Date of Birth:_______________________ SSN:_______________________

Information Requested:

____ Copy of Complete Dental Chart
____ Copy of Dental Radiographs
____ Other ______________________________

Purpose or need for which information is to be used:

Transfer of Records ____ Second Opinion ____ Other ______________________________

Authorization: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

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Signature of Patient or Guardian Date