REQUEST FOR RELEASE OF RECORDS TO NEW DENTIST

I,_____, request and give my permission to **Dr. Michael C. Oakes, DMD, 1111 East Reserve, Vancouver, Washington 98661,** to provide any and all information/radiographs in respect to the dental treatment of _____(patient's name or family members' names).

Send records/radiographs to:

Dr. Name _____
Address _____
_____

A fax or photocopy of this release will be as effective and valid as the original.

Signed _____ Date _____

Signed _____
(Parent, legal guardian, custodian of patient if patient is a minor)

Patient address: _____

_____