**BEYER FAMILY DENTAL**

**333 WARNER MILNE RD. SUITE A**

**OREGON CITY, OR**

**503-655-0613 FAX 503-655-3674**

beyerfamdental@gmail.com

Authorization for release of dental records,

I _____, hereby authorize

(Prior dentist name) _____ to release dental records pertinent to my continuing care including any radiographs, chart notes, and dental/periodontal charting to:

**BEYER FAMILY DENTAL**

**333 WARNER MILNE RD. SUITE A OREGON CITY, OR**

Patient name _____

Date _____

Authorization signature _____

Relationship to patient _____`