Wark Dental Group
2177 NW 2nd St.
McMinnville, OR. 97128
503-472-2125

Authorization to Release Dental Information

Please return this form prior to appointment to ensure we have relevant information from previous dentist which could save you on the cost of new x-rays if they are current.

Patient Information

Name: ____
DOB: ____
Address: ____
City: _______________________State:____________
Zip: _______________________

Please release recent x-rays, and pertinent treatment information from:

Previous Dentist/Doctor:

Name: ____
Address: ____
City: _______________________State:____________
Zip: _______________________
Phone: ____________________Fax:________________

Send To:

Amy R. Wark, D.M.D.
2177 NW 2nd St.
McMinnville, OR. 97128 X-rays may be e-mailed to: frontdesk@amywarkdmd.com

The above named is authorized to release my records as indicated. This release of information authorization is valid for six (6) months and may be revoked at anytime.

Patient Signature:____________________________________Date:_________________

Parent/Guardian Signature:__________________________Date:_________________
(if applicable)