AUTHORIZATION TO RELEASE INFORMATION

Ben Thomas DMD
895 Country Club Road Suite C-15
Eugene, Or 97401
541 484-1235 Fax 541 431-0212

DATE: _____

I, _____, give permission to have the indicated

Records released for patient or patients:

_____

Include:

_____Radiographs

_____Perio Charting

SEND TO THE OFFICE OF

Dr._____

ADDRESS_____

CITY/STATE/ZIP_____

PHONE NUMBER_____FAX_____

Signature of patient: _____

Legal guardian of _____