Date: _____

Patient Name: _____

DOB: _____ Phone: _____

I _____, authorize the release of the most current:
BWX, PANO AND/OR FMX and periodontal charting from:

_____(name of provider) to Lake Oswego Smiles.

*I also give my permission for my providers to coordinate care with each other when necessary.

Patient/Guardian Signature: _____

Please forward to:

Dale L. McNutt, DMD
Lake Oswego Smiles
16699 Boones Ferry Road, Suite 200
Lake Oswego, OR 97035
Email: Office@OswegoSmiles.com
Phone 503-635-3653