DENTAL OASIS
of Clayton

Authorization for the Request of Records and X-rays

I, _____ (print patient or guardian name) request my records be sent via mail or email to Dental Oasis of Clayton. I do hereby authorize the doctors and staff of _____ to release records or knowledge concerning my dental health.

I specifically request that you release copies of:

all x-rays all treatment notes

Signed (patient or guardian) _____

Printed name (patient or guardian) _____

Dental Oasis of Clayton
452 Shotwell Road
Clayton, NC 27520

919.550.5200 Office
919.550.5240 Fax
drhumble@dentaloasisclayton.com