PARKWOOD DENTAL
OSCAR HERNANDEZ, JR. D.M.D.

Authorization for Records Release

Date of Request: ________________________

Patient Name: __________________________________ Patient Date of Birth: ________________________

FROM: Oscar Hernandez Jr, DMD, Oscar J. Hernandez, DMD & Thao Nguyen, DMD

I hereby authorize the release/request (circle one) of copies of my dental records and radiographs and request that they are transferred to:

Name of Patient/Dentist (circle one) __________________________________

Address _________________________________ City/State/Zip ______________________________

Telephone # _____________________________ Email address _______________________________

To be sent via: ☐ mail ☐ e-mail

Signature of Patient/Guardian: __________________________________

For internal use only:

Date received: ________________________ Staff signature_____________

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