Authorization For Release of Records

☐ For transfer of records **TO** Eleven Eleven Dental

☐ For transfer of records **FROM** Eleven Eleven Dental

Patient Name:_____

Date of Birth:_____ Phone Number:_____

Other family members to transfer:_____

Previous Dentist or Practice Name:_____

Address:_____

City/State/Zip:_____

Phone Number:_____ Email:_____

Please forward any of the following records:
*Bitewing X-rays within 1 year
*Full mouth x-ray and panorex within 5 years
*Perio Chart and date of last prophy, Perio maintenance and / or scale & root planing.

I hereby give my permission for you to release any and all of my dental records.

_____ _____
Patient Signature (Guardian if Minor) Date

If records are digital, please email to : Info@1111Dental.com

Or mail to : 1111 Dental
1111 Columbia Street
Port Angeles, WA 98362

Phone: 360-457-3183
Fax: 360-457-6875