Thomas Orazio DMD
9370 SW Greenburg Rd #103
Portland, OR 97223
503-245-0082

Patient's Name: _____

Date of Birth: _____

I hereby authorize: _____

To provide dental information to: **office@drorazio.com**

Thomas V. Orazio, D.M.D.
9370 SW Greenburg Road
Franklin Bldg. Suite 103
Portland, OR 97223
Fax: 503/ 245-0293

The following information is to be released for the purpose of patient care: history, X-rays, photographs, periodontal charting, etc.

Most recent: FMX, BWXs, Pano & Periodontal Charting
I consent to the release of the above information and health records obtained in the course of my diagnosis and treatment. I understand that such information cannot be released without my consent, except in a medical emergency.

This authorization is valid for six months unless revoked in writing.

Signature:_____ Date:_____