



**Oasis Dental Clinic**

19533 Doctors Drive  
Germantown, MD 20874  
P:( 240) 246-7900 F:( 240) 246-7479

I, \_\_\_\_\_ hereby authorize the Oasis Dental Clinic to release my dental records. These records may include X-rays, Treatment Notes, Charting, Medical and Dental History, Photographs, or other notations relevant to my treatment.

These records may be released to: (Choose One)

1.) My Dentist/Doctor: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

2.) Send to My Personal E-mail: \_\_\_\_\_

3.) Release to person authorized by me:

Authorized person's name: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you have any comments about our practice, feel free to write them here:

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