*J. Michael O'Gara D.D.S.*
*Tricia O'Gara D.D.S*
*Phone: (775) 329-6183*
*Fax: (775) 329-6987*
*645 W. Sixth Street  Reno, NV 89503*

**AUTHORIZATION TO OBTAIN AND RELEASE PATIENT RECORDS**

Patient Name: _____

Address: _____

_____

Phone: _____ Date of Birth: _____

I HEREBY AUTHORIZE TO (COMPLETE ONE)

**RELEASE** PATIENT RECORDS **TO** PARTY LISTED BELOW:

J MICHAEL O'GARA DDS

645 W 6TH STREET

RENO NV 89503

775-329-6183 ogardental@yahoo.com

**OBTAIN** PATIENT RECORDS **FROM** PARTY LISTED BELOW:

Doctor Name/Facility:_____

Address: _____

City/State/Zip Code: _____

Phone/Fax: _____

_____ _____
Signature Date

_____ _____
Witness Date