Authorization To Release Dental Information

Goodall Family Dentistry
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I hereby authorize _____ to release/email the following information from my dental record to Goodall Family Dentistry.

____ Clinical Progress Notes

____ X-rays Bitewings (within 2 year)
Panoramic or Full Mouth Series (within 5 years)

____ Other (Please Specify) _____

I understand that this consent is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either six months after the date of signature or automatically when the records requested on this authorization have been mailed to the requestor.

Patient's Name (Print)_____

Date _____ Signed_____

Date _____ Witness _____

If patient is unable to give consent because of physical condition or age, complete the following:

Patient (is a minor ____ years of age) or (is unable to give consent because_____)

Date _____ Signed _____
(Signature of legal guardian and relationship)