CONSENT TO RELEASE DENTAL RECORDS

Patient name and date of birth: (please print)

____

Release records to:

____
Name of dentist

____
Mailing address

____

____
Email address

What are you requesting?

_____Copy of bitewing x-rays
_____Copy of panoramic x-ray
_____Copy of dental treatment notes

_____Other____

I hereby consent and authorize release of my dental records to the office named above:

____
Signature and date
*If not patient, state relationship for authorization:______________________

According to Colorado state law all dental records remain the exclusive property of the dental office of origin. With proper written authorization patients are allowed access and copy of their dental records.

Andrew R. Gall, DDS
132 Walnut Avenue
Grand Junction, CO 81501

970-245-1758
970-245-1759 (Fax)
drgall@drandrewgall.com