CONSENT TO RELEASE
PATIENT CHARTS & MEDICAL INFORMATION

Date: ____

Forward to:

Doctor: ____

Address: ____

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For valuable consideration, I hereby irrevocably consent to and authorize the transfer by you, or anyone authorized by you, of my patient charts and any medical information that you have gathered of me for any purpose whatsoever, to Dr.________ ________________________________ (dentist) without further compensation to me.

I am over 19 years of age: Yes__________ No___________

Patient Name: ____

Patient Address: ____

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Patient Signature: ____

If the patient is under the age of 19 years, a parent or guardian should give consent as follows:

I hereby certify that I am the parent or guardian of ______________________________ ____________________, the model for whom named above, and for value received I do give my consent without reservations to the foregoing on behalf of him or her or them.

Date: ____

Print Name: ____

(Parent / Guardian)

Signature: ____