CONSENT FOR DR. CHRISTENSEN TO SEND PATIENT RECORD INFORMATION

Patient's Full Name: ____ Date of Birth: ________________

Patient's Address: ____

Number & Street City State Zip

Parent's Name: ____

I hereby authorize the office of John R. Christensen, DDS, MS, MS to **RELEASE** information to:

Name: ____

(Dentist, hospital, school or individual you want information **SENT** to)

Please send this information via:

- ☐ Fax: (Fax Number) ____
- ☐ Email: (Email address) ____
- ☐ Mail: (Address) ____

Number & Street City State Zip

Information to Be Released:

- ☐ Bite-Wing Radiographs
- ☐ Periapical Radiographs (P.A.)
- ☐ Panoramic Radiographs (Panorex)
- ☐ Cephalometric Radiograph (Ceph)
- ☐ Pediatric Dental Treatment History
- ☐ Orthodontic Casts
- ☐ Please send all pertinent radiographs & treatment history.
- ☐ Other: ____

____

Dates of Service:

- ☐ Covering the period of care from: ________________________ to ___________________________
- ☐ All dates of service

I understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

Dr. Christensen by releasing authorized information is hereby relieved from all legal responsibility of liability for the release of the information described above to the extent indicated and authorized herein.

____ ________________________

Signature of Parent Date

____ ________________________

Signature of Witness Date

Growing healthy smiles!

John R. Christensen, DDS, MS, MS ~ Pediatric Dentistry & Orthodontics ~ 121 W. Woodcroft Parkway, Durham, NC 27713

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