

CONSENT TO SEND PATIENT RECORD INFORMATION TO DR. CHRISTENSEN

Patient's Full Name: _____ Date of Birth: _____

Patient's Address: _____
Number & Street City State Zip

Parent's Name: _____ Date of Birth: _____

I hereby authorize: _____
(Dentist, hospital, school or individual SENDING information)

To **RELEASE** information to: **John R. Christensen, DDS, MS, MS**
Pediatric Dentistry & Orthodontics
121 W. Woodcroft Parkway
Durham, NC 2772
Office: (919) 489-1543
Fax: (919) 489-2892
Email: marycarter@drjohnsoffice.com

Information to Be Released:

- | | |
|---|--|
| <input type="checkbox"/> Bite-Wing Radiographs | <input type="checkbox"/> Periapical Radiographs (P.A.) |
| <input type="checkbox"/> Panoramic Radiographs (Panorex) | <input type="checkbox"/> Cephalometric Radiograph (Ceph) |
| <input type="checkbox"/> Pediatric Dental Treatment History | <input type="checkbox"/> Orthodontic Casts |
| <input type="checkbox"/> Please send all pertinent radiographs & treatment history. | |
| <input type="checkbox"/> 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!