

# Authorization To Release Dental Information

## Goodall Family Dentistry

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Xrays@GoodallFamilyDentistry.com

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)