CONSENT TO RELEASE DENTAL RECORDS

To Dr: _____

Patient name and date of birth: (please print)

_____

Release records to:
Andrew R. Gall, DDS
132 Walnut Avenue
Grand Junction, CO 81501
970-245-1758
or
drgall@drandrewgall.com

Copies of the following records are being requested:

- ✓ Bitewings within the past 12 months
- ✓ Full mouth series or pano within past 5 years
- ✓ Progress/Treatment notes
- ✓ Perio charting
- ✓ Letters/reports from specialists

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.