Jeffrey D. Carl, DMD PC
Christopher D. Walker, DMD

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Telephone (541) 926-6089
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Date of Request_____

My permission is granted to Dr. _____to disclose to Dr. Jeffrey Carl DMD PC and Christopher Walker, DMD -Complete information without limitations regarding the medical findings and treatment past, present, or future of

_____
(Patient and /or Patients)

This includes dental history, x-ray findings, diagnosis, prognosis and access to all records and photocopies of the same.

I release Dr._____ from any laws related to disclosure of confidential or privileged information.

_____
(Signature of patient or person authorized to consent for patient)

Address _____

Witness _____ Date _____

Please EMAIL Digital X-rays to: cindy@jeffcarldmd.comcastbiz.net

PLEASE COMPLETE DATE OF X-RAYS & TREATMENT AND RETURN A COPY OF THIS PAGE Via FAX (541) 926-6196.

Full Mouth Series Taken: _____
Panorex Taken: _____
Bitewing x-rays: _____
Last Recall Exam: _____
Last Prophy: _____
Last Periodontal Charting: _____