Jeffrey D. Carl, DMD PC

3120 Pacific Place SW
Albany, Oregon 97321

Telephone (541) 926-6089
Fax (541) 926-6196

Date of Request_____

Previous or Current Dentist

Dr. _____
Address:_____
Phone:_____ Fax:_____

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

_____DOB_____
_____DOB_____
_____DOB_____
_____DOB_____

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)

Please EMAIL Digital X-rays to: records@jeffreycarldmd.com

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: _____

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