



Wake Dental Care
3100 NC Highway 55, Suite 201
Cary, NC 27519
Phone - (919) 363-3133
Fax – (919) 363-3134
WakeDentalCare@gmail.com

I hereby authorize _____ to release/email the following information from my dental record to Wake Dental Care:

- _____ Clinical Progress Notes
- _____ X-rays Bitewings (within 2 years)
Panoramic or Full Mouth Series (within 5 years)
- _____ Other (Dates of Prosthetics, if applicable) _____

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)