



Wake Dental Care  
3100 NC Hwy 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:

\_\_\_\_\_ X-rays     Bitewings (within 2 years)  
                         Panoramic or Full Mouth Series (within 5 years)

\_\_\_\_\_ Clinical Progress Notes

\_\_\_\_\_ Other (dates of prosthetics, if applicable) \_\_\_\_\_

I understand that this content 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)