DISCOVER DENTAL
Dr. Jeremie Hallett DMD

Release of Records

Patient Name:

For valuable consideration, I hereby irrevocably consent to and authorize the transfer by Dr. Jeremie Hallett, or anyone authorized by Dr. Jeremie Hallett, of my patient charts and records. These records may include x- rays, treatment notes, charting, medical and dental history, photographs, models, or other notations or information that has been gathered of me for any purpose whatsoever.

Circumstances of release: *(please choose one and fill out information as needed)*

- ◯ **Release to my dentist** Dr.
  Address:
- ◯ **Release to my home address:**
- ◯ **Records will be picked up by:**
- ◯ **I will pick up records in person**

Email (for X-Rays)

Patient Signature
(over 19 years old)

Signature

or

Legal Guardian
(if patient younger than 19 years old)

Signature