CONSENT TO RELEASE DENTAL RECORDS

Date: _____

I, _____, do hereby consent and authorize Dr. Karen McCarthy to disclose to _____
(Responsible Party) (Name of Party)

all information in the Shasta Orthodontic records related to the below listed patient.

Patient Name: _____

Patient DOB: _____

Responsible Party (Print Name):

_____

Responsible Party (Signature):

_____

Relationship To Patient:

_____

Please Sign and Mail or Fax To:
Shasta Orthodontics Dr. Karen McCarthy D.D.S., M.S. 68 Hartnell Avenue Redding, CA 96002 Fax: 530-223-6910

If you have any questions, please call our office: 530-223-6850