



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**