

*MEDICAL & DENTAL INFORMATION RETRIEVAL PERMISSION*

Name of patient \_\_\_\_\_

I hereby give permission for Dr. Gold, and his office staff to contact the dentists and physicians of the above mentioned person to request and exchange information related to her/his orthodontic treatment. This information may be verbal or written, and may include diagnostic material such as radiographs (x-rays), study models, and photographs.

\_\_\_\_\_  
Name of Patient / Responsible Party

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date