L. Justin Payne, DMD
FAMILY AND COSMETIC DENTISTRY

Authorization for Records Release

Patient Name:_____ Date:_____

Patient DOB:_____

I hereby request and authorize the below named person or entity to forward a copy of my current dental records to the office of L. Justin Payne, D.M.D.

Practice or Dentist Name: _____

Office Phone: _____

These records include, but are not limited to: personal patient information, medical and dental histories, examination records, radiographs, clinical photographs, treatment plans, treatment records, referral and consultation recommendations and reports, diagnostic models and other related materials.

I expressly release from liability the above named person or entity from any and all liability arising from compliance with this request and disclosure of the requested information.

Date: _____

Patient Signature: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Please remit requested information to:

L. Justin Payne, D.M.D., P.C.
5391 Highway 53, Suite 101
Braselton, GA 30517
Main: (706) 654-1557
Fax: (706) 654-1557
ljustinpaynedmd@windstream.net