MCDANIEL FAMILY DENTISTRY
7509 Six Forks Rd, Raleigh, NC 27615
(919 847-5959

# DENTAL RECORDS RELEASE FORM

Name:_____ Date of Birth:_____

## AUTHORIZES

_____
Name of Practice

_____
Address

_____
City State Zip Code

_____
Email Phone Fax

## TO DISCLOSE TO

**DELIVERY OPTION:** ☐ Mail ☐ Email ☐ Fax

**SEND TO**: MCDANIEL FAMILY DENTISTRY
7509 SIX FORKS RD, SUITE 202 RALEIGH, NC 27615

**PHONE:** 919-847-5959
**FAX**: 919-844-9341
**EMAIL**: MCDANIELFAMILYDENTISTRY@GMAIL.COM

## INFORMATION TO BE DISCLOSED:

*Only information from the past five (5) years need be disclosed. Uless dates filled in below:*
*From:* _____ *To:* _____

☐ Current x-rays (bitewing x-rays, full mouth x-rays, & panorex)
☐ Treatment dates for prophy's, exams, and scale & root planning ☐ Treatment Plans ☐ All Billing Records

Specific records/information as follows: _____
_____

## SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE:

_____ Date: _____
*If signed by a person other than the patient, complete the following:* Individual is
☐ parent/legal guardian ☐ legally incompetent ☐ incapacitated/deceased
☐ next of kin/executor of deceased

**By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by _____.**