DENTAL RECORDS RELEASE FORM

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

AUTHORIZES:

_____

TO DISCLOSE TO: ☐ Self ☐ Dental Provider ☐ Other _____
Delivery options ☐ mail ☐ delivery ☐ email ☐ fax ☐ pick up *(please fill in below)*

To be picked up by, I hereby authorize _____ to pick up my records. (Photo ID required.)

Send to: **McDaniel Family Dentistry**
Name of Health Care Provider / Plan / Other/ Myself

7509 Six Forks Rd. Raleigh, NC 27615
Address

PHONE: **(919) 847-5959** FAX #: **(919) 844-9341**

EMAIL : **mcdanielfamilydentistry@gmail.com**

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

When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays & panorex) within the last 5 yrs and treatment dates for prophy's (cleanings) – exams – scale & root planning.
To send just this basic information described above please check here ☐

****If you want us to release other information then please mark below.****

INFORMATION TO BE DISCLOSED:

Treatment plan ☐ Radiology films/images ☐ 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 _____