Consent for Medical Records Release

I hearby authorize Dr. _____ to release copies of my dental treatment records and originals or duplicates of any current x-rays to the dental office of:

Waldron & Lee Dentistry

2419 Roswell Road

Marietta, GA 30062

770-977-5547

Patient's Name: _____

Date of Birth: _____

Patient Signature: _____ Date: _____

(Parent or legal guardian must sign if patient is a minor)

For Office Use Only

Request sent on: _____

Request received on: _____

Date sent: _____

Records and x-ray to be sent: _____