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 Dentistry

3020 Roswell Road Suite 100

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)

<u>For Office Use Only</u>

Request sent on: _________________

Request received on: ________________

Date sent: ___________________

Records and x-ray to be sent: _________________