4704 Main Street Shallotte, NC 28470 ⬨Phone: 910-755-7645⬨Fax: 910-755-7646

Patient Authorization for Release of Records

I hereby authorize Shallotte Family Dentistry to receive and/or release records for the below individuals.

I understand I may revoke this consent in writing at any time except to the extent that action has already been taken on it and that this request will expire ninety days from the date of authorization. I further understand that Shallotte Family Dentistry has no control over the distribution of requested records by the persons or entities to which the records are being released.

By signing this form the patient and/or legal guardian agrees to hold harmless Shallotte Family Dentistry from any and all responsibility and liability that may arise from complying with this signed authorization and consent to release the patient's dental records.

Patient Name: ____

Date of Birth: ______________________________ **Last 4 of Social Security #:** _______________________

Address: ____

Phone Number: ____

Information to be released:

_____ All records (x-rays, clinic notes, lab reports, treatment plans, etc)

_____ Specific information only (please list)

_____ Covering care from ________________ to _________________

_____ Requesting records to be released to Shallotte Family Dentistry via secure email; ShallotteFamilyDentistry@gmail.com

_____ Requesting Shallotte Family Dentistry release records to the below person or practice;

Name: ____

Address: ____

Phone Number: _________________________________ **Fax Number:** ___________________________

Email: ____

Patient/Guardian Signature: ____ **Date:**_________________