CONSENT FOR RELEASE OF DENTAL RECORDS

I, _____ do hereby consent to and authorize
(Name of Patient)

Dr._____ to disclose to:

Name: Dr. Adam C. Harrell

Address: 110 Oakmont Drive

Greenville, NC 27858

information in my dental record, including current and previous dental records from other practices and practitioners, hospitals, and/or clinics which are a part of my dental record.

The following information is strictly for purposes of identification:

Patient's Date of Birth:_____
(month/day/year)

Signed_____
Patient

Date:_____

✓ Send the information electronically. Email address: acapps@greenvillencdentist.com

THIS CONSENT EXPIRES ONE YEAR FROM ABOVE DATE.

List all children's names (UNDER 18) & dates of birth for all records that need to be transferred:
(NOTE: Patients 18 years old and older must sign a separate form)

Name	Date of Birth

(If additional consent is necessary from a person authorized to give consent, other than the patient, such as a parent, guardian, etc., obtain signature.)

Signed:_____
Authorized Person

Date:_____

Reason for Leaving:

_____

_____