

**CONSENT FOR RELEASE OF DENTAL RECORDS**

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

Dr. \_\_\_\_\_ to disclose to:

Name: \_\_\_\_\_ Dr. Randy G. Fussell \_\_\_\_\_

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: [dmatthews@greenvillencdentist.com](mailto:dmatthews@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)**

<u>Name</u>	<u>Date of Birth</u>
_____	_____
_____	_____
_____	_____

(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: \_\_\_\_\_

<b>Reason for Leaving:</b>   
--