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: mcullipher@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:

____

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