

DEBORAH G. ANDERS, DDS, PA
General Dentistry
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TRANSFERRING RECORDS TO OUR OFFICE
CONSENT FOR RELEASE OF DENTAL RECORDS

I, _____, do hereby consent to and authorize Dr. _____ to disclose to Dr. Deborah G. Anders at 3094 US 70 Hwy, Black Mountain, NC 28771 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.

My date of birth is (month/day/year) _____, and my social security number is _____. This information is strictly for purposes of identification.

Signed: _____ Date: _____

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

Signature of Parent, Guardian, Etc.: _____
Relationship to the Patient: _____
Date: _____

Name and Address of the Dentist from whom you are requesting records:

Telephone #: _____