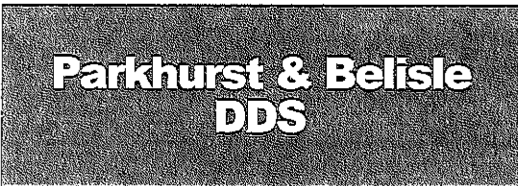
5503 Oleander Drive
Wilmington, NC 28403
910-392-1905
910-392-0462
www.parkhurstbelisle.com



Authorization to Release Dental X-rays/Records:

____
(Patient Name) (DOB)

I ____ hereby authorize
(Patient or Parent/Guardian Name)

____, to **release to**
(Name of Dental Office)

____ any copies of any and
(Name of Dental Office)

all of my dental records, including but not limited to, treatment records, medical and dental history records, dental hygiene records, x-rays, operative notes, records of administration of local or general anesthesia, records of the administration and/or dispensation of drugs, medication, anesthetics, including controlled substances, payment record, laboratory prescriptions, insurance forms/claim records, diagnostic/treatment models, or any other document or information pertaining to my treatment.

Please email records to info@parkhurstbelisle.com

____
(Signature of Patient or Parent/Guardian) (Date)