J. Michael Carpenter, DMD, PLLC
P.O. Box 699 & 111 S. Davis St.
Pilot Mountain, NC 27041

CONSENT FOR RELEASE OF DENTAL RECORDS

Patient Name: _____

Date of Birth: _____/_____/_____

Social Security Number: _____ - _____ - _____

I, _____, do consent to and authorize _____ to disclose to _____, any information in my dental records, including, but not limited to, current and previous records from other practices, which are part of my records.

Patient Signature: _____

Date: _____/_____/_____

(If not able to obtain patient signature, signature of authorized person is required)

Signature: _____

Date: _____/_____/_____

PLEASE EMAIL CURRENT RADIOGRAPHS TO: info@foothillfamilydentistry.com