REQUEST FOR RELEASE OF HEALTH INFORMATION

I, _____ hereby grant permission to
(Print Name)

_____
(Print Name of Doctor or Hospital)

to release information related to my health history, status, and treatment, and copies of my health record, X-rays, and any test results (Protected Health Information) to:

_____

At Albemarle Road Family Dentistry
6404 Albemarle Road, Ste B&C, Charlotte, NC 28212
Phone: (704) 910-4720 Fax: (704) 910-4120
e-mail: ptcare@arfamilydentistry.com

Signature _____ Date _____
(If a minor, parent or guardian must sign)