Midtown Family Dentistry

FAMILY & COSMETIC DENTISTRY

I, _____ hereby authorize

Dr. _____

(Street)_____

(City, State, ZIP)_____

(Phone)_____

To release any and all medical records and x-rays to:

Midtown Family Dentistry
217 W. Millbrook Road, Suite B
Raleigh, NC 27609
Email: **scheduling@raleighmidtownfamilydentistry.com**

The records to be sent are for the following family members:

Full Name:_____ DOB_____
Full Name:_____ DOB_____

The authorization to release the information on the above named patient(s) is subject to the following statement. State law prohibits you from making further disclosure of such information without specific written consent of the person(s) to whom the information pertains or is otherwise permitted by state law.

Signature:_____ Date:_____

Street
Address:_____

City, State, Zip_____

Phone:_____