DENTAL RECORD RELEASE FORM

Patient Name to Transfer: ____

Date of Birth: ___________________Phone Number: _________________

Other Family Members to Transfer: ____

Previous Dentist or Practice Name: ____

Address: ____________________________________ City/St./Zip: ______________________

Phone Number: __________________

Patient Rights:

- **I have the right to revoke this authorization at any time.**
- **I may inspect or copy the protected health information to be disclosed as described in this document.**
- **Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.**
- **Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.**
- **I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.**

Please forward any information and radiographs you may have on file.

I hereby give you permission to release all previous dental records.

Signature: ____ Date: ________________

If records are digital, please email to: mrfdoffice@gmail.com
Or mail to:

Mills River Family Dental
3340 Boylston Hwy., Unit 30
Mills River, N.C. 28759
828-891-7999