Records Release Form

Patient Information:

Name of Patient _____ Date of Birth _____

Current Address _____

Current Telephone _____

Information Released From:

Information Released To: Wingate Dental Care

207 W. Wilson Street Wingate, NC 28174

Phone: 704-233-5545 : Fax: 704-233-9597 :

Information@Wingatedentalcare.com

Information to be forwarded to health care provider:

Panoramic X-ray _____ Bitewing X-rays _____ FMX _____

Progress Notes _____ Other: _____

This authorization shall be in effect until the information has been forwarded as requested.

I understand that my treatment will not be conditioned on signing this authorization, and that I have the right to refuse to sign this authorization, but that without my signature on this authorization the above listed office is not allowed by HIPAA Law to release my records unless they are being released for insurance purposes or for referral purposes (as underlined in my signed HIPAA release form in my chart). I understand that I have the right to revoke this authorization in writing, and that a revocation is not effective if the information has already been forwarded.

_____ _____

Signature of patient, or Parent and/or Guardian Date