REQUEST FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____

DOB: _____

I, _____

(Relationship to patient: Self / Spouse / Parent or Guardian), hereby grant permission to:

Albemarle Road Family Dentistry

6404 Albemarle Road, Ste B & C

Charlotte, NC 28212

(704) 920-4720

ptcare@arfamilydentistry.com

to release information related to the above patient's health history, status, and treatment, and copies of record, x-rays, and any test results (Protected Health Information) to:

Name of Dental Office: _____

Mailing Address: _____

Phone Number: _____

E-mail Address: _____

Signature: _____ Date: _____

(If a minor, parent or guardian must sign)