

# Release and Request for Patient Records

Date \_\_\_\_\_

To: \_\_\_\_\_  
Name of Dentist/Specialist

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

I authorize the release of dental records and any medical records relevant to dental treatment, or copies of such records, and request that they be transferred to:

Melissa Owen, DDS  
1108 Eastowne Court  
Leland, North Carolina 28451

These records are needed ASAP.

If the named patient does not have current x-rays available please contact our office, at 910-371-5965, to advise.

Please send Digital x-rays as a .jpg file only to:

**frontdesk@lelanddentalarts.com**

Patient: (Please Print) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of Patient,  
Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_