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 R. Owen, PLLC
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:_____