Central Virginia Family Dentistry

CONSENT TO RELEASE DENTAL RECORDS

Patient Name: _____

Date of Birth: _____

You are authorized to release dental information contained in my records for the period of my first office visit through the current date to the following office.

_____

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I specifically request that the following type of information be released:

- Dental X-rays (Bitewings, Panoramic, PA's, etc.)
- All Dental Procedure Records
- Patient Information and Health History

I release the above named dentist and/or practice from liability and claims of any nature pertaining to the disclosure of requested information contained in my dental records. This authorization continues until revoked.

Signature: _____ Date: _____/_____/_____

Please email to: cvfdlynchburg@centralvafamilydentistry.com

20936 Timberlake Road
Lynchburg, VA 24502
Phone: (434) 237-0004
Fax: (434) 237-6597