Myrtle Beach Dental Associates, PA

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CONSENT FOR RELEASE OF DENTAL INFORMATION OR RECORDS

I Hereby Authorize:
Name of sending office or doctor:____

To Release To:
Name of receiving office or doctor: ________Myrtle Beach Dental Associates________

Send Records To:

Address:________8151 Rourk Street - 82nd Parkway_________

City:_____Myrtle Beach_______ State:_____SC_____ Zip Code:_____29572_____

E-Mail Address:_________MBDentalAssociates@gmail.com____________

Information Pertaining to the Care and Treatment Of:

Patient's Name:____

Date of Birth:____

Phone Number:____

I authorize the release of any and all dental records and x-rays that relate to my dental care while a patient at your office.

Patient's Signature:____

Date:_____________________________

We prefer all x-rays to be sent digitally, via email in JPEG form. Thank you!