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:_____
City/State_____Ph#:_____

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!