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RELEASE OF DENTAL INFORMATION

Patient Name: _____ DOB: _____

___ Release **TO** Winslett & Walls Dental Excellence
I hereby authorize the release of my dental records to Winslett & Walls Dental Excellence from the following dental practice:

Name of practice: _____

Address: _____

Phone: _____ Fax: _____

___ Release **FROM** Winslett & Walls Dental Excellence
I hereby request that Winslett & Walls Dental Excellence release my dental records to the following dental practice:

Name of practice: _____

Address: _____

Phone: _____ Fax: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information.

Notice of Privacy Practices: You have the right to read our Notice of Privacy practices before you sign this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form.

_____ _____
Signature of patient/guardian/representative Date