ANCHOR
DENTAL

Authorization for Release of Records

I,______________________________, authorize the release of dental records to Anchor Dental located at 3718 N. Hwy 16, Denver, NC 28037.

Name: (if different than above):

DOB:

I specifically request that you release copies of:

___ X-Rays ______ Treatment Notes

Email records to: davidreidspiveydmdpllc@gmail.com

Mail Records to: **Anchor Dental**

P.O Box 154

Denver, NC 28037

Signature of Patient: ________________________________ Date: __________

Signature of Parent/Legal Guardian: __________________________ Date: __________