

Consent for Medical Records Release

I hereby authorize Dr. _____ to release copies of my dental treatment records and originals or duplicates of any current x-rays to the dental office of:

Drs. Waldron, Waldron & Schlissel
3020 Roswell Road Suite 100
Marietta, Ga 30062
(770) 977-5547

Patient's Name: _____

Date of Birth: _____

Patient Signature: _____ Date _____

(Parent or legal guardian must sign if patient is a minor)

For Office Use Only

Request sent on _____

Request received on _____

Date Sent _____

Records and x-ray to be sent _____
