201 Providence Road
Charlotte, NC 28207
704.376.6470

MEDICAL RECORDS RELEASE AUTHORIZATION FORM

I, __________________________ (date of birth ____________), would like to request to have copies of my treatment records and any radiographs sent to the email address listed below or to my insurance company and/or other necessary parties.

To transfer x-rays (radiographs)/records **TO** our office, please email X-rays/ images to: **xrays@charlottedentistry.com**

OR

To transfer x-rays (radiographs)/records **FROM** our office, please email X-rays/images to:

____.

Patient: ____

Parent/Guardian: ____

Date: ____