1407 Hillsborough Street….Raleigh, NC 27605…..919-834-1432 (off).....919-977-3102 (fax)…..info@hsdentist.com

AUTHORIZATION TO RELEASE DENTAL RECORDS

Date: ____________________

I hereby request and authorize Hillsborough Street Dental to release my records to the following office.

Please complete any and all members of the family for whom records are being requested. Please note that only minor children are to be included in this form along with an adult (if any). Each adult patient must have a separate authorization complete with his/her own signature.

Dental Off Name:________________________________ **Address:**_________________________ (Optional)

Off #:(Required)____________________________ ______________________________________

Off fax #:(Required)_________________________ ______________________________________

Off email:(Required)____

*** All xrays are digital and can only be sent via email; therefore, if we are not provided with an email address then xrays will not be sent. We do not provide copies of xrays ***

Please list all patients for whom you would like information to be sent for:

Patient Name: _______________________________________ DOB: _________________________

Patient Name: _______________________________________ DOB: _________________________

Patient Name: _______________________________________ DOB: _________________________

Patient Name: _______________________________________ DOB: _________________________

Patient Name: _______________________________________ DOB: _________________________

Reason for transfer: ____

List any additional remarks: ____

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Patient/Parent/Guardian Signature: _________________________________ **Date:**__________________

Thank you and have a great day.
Sincerely,
HSDA