Records Release Form

I, _____, give permission for_____
(name of patient or legal guardian) (name of releasing doctor)

Phone number _____
(phone number of releasing doctor)

to release medical information (Diagnosis Codes, X-rays, Clinical Notes and Operatory Notes) on the following patient

_____ to the dentist listed below.
(name of patient)

Patient's Date of Birth ___/___/_____

Signature of patient or legal guardian: _____

Date: ___/___/_____

Email to: stacey@tennesseedentalcare.com
Fax to: 615-690-5404

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Dr. George H. Clayton
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