



**MEDICAL RECORDS RELEASE AUTHORIZATION**

I, \_\_\_\_\_, hereby authorize Dr. \_\_\_\_\_  
(Patient name)

to release copies of my treatment records and any radiographs to the doctor’s office listed below, or to my insurance company and/or other necessary parties.

I understand that these records and x-rays will be used for treatment purposes, or for claims processing and/or benefit disbursement.

Please forward all information to the address listed below. Thank you for your prompt response.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guardian (if Patient is a Minor)

\_\_\_\_\_  
Date

E-MAIL DIGITAL X-RAYS TO:  
[xrays@charlottedentistry.com](mailto:xrays@charlottedentistry.com)

Charlotte Dentistry, Armstrong & Eshleman, PA