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

(from: _____), 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: _____