AUTHORIZATION TO RELEASE DENTAL RECORDS

I, the below named patient, request the dental records as noted to be **RELEASED TO**:

Plage Dentistry
Dr. Robert Plage, Dr. Michael Plage
1802 New Hanover Medical Park Drive, Wilmington, NC 28403
office@plagedentistry.com

Patient's Name: _____

Patient's Date of Birth: _____

RELEASED FROM:

Dentist Name: _____

Address:_____

Email:_____

Phone:_____

I request copies of the following dental records:

_____ Most recent dental records & x-rays

_____ Current x-rays only (FMX/Pano within 5 years and BWX/PA films within 1 year)

_____ Other_____

*Signature: _____ Date: _____
(Patient or Guardian must sign if requesting for a minor)

*The patient(s)/parties acknowledge and agree that this "AUTHORIZATION TO RELEASE DENTAL RECORDS" form may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature. Without limitation, "electronic signature" shall include faxed or emailed versions of an original signature or electronically scanned and transmitted versions (e.g., via pdf) of an original signature.