Asheville Family Dentistry

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REQUEST FOR RELEASE OF DENTAL RECORDS/X-RAYS

Patient Name: _____

Date of Birth: _____

Who may we contact to obtain your records?

Dr. _____

Address: _____

Phone #: _____

Email & Fax# _____

I request my dental records/x-rays be released to:

Asheville Family Dentistry
Callan D. White, DDS, PLLC
Allison J White, DDS
1011 Tunnel Road, Suite 140
Asheville, NC 28805

Email Address: Info@ashevillefamilydentistry.com

Patient's Signature: _____

Date: _____

If guardian to patient, state relationship: _____
Office Representative: _____
NOTES: _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.