

# PATIENT RECORDS RELEASE



I, \_\_\_\_\_, hereby authorize the release of my dental records, and those of my family members listed below:

\_\_\_\_\_

\_\_\_\_\_

Please include a complete history of treatment, as well as copies of any radiographs taken (you may email them if you have that ability). Please send them to:

Spring Lake Dental Group - Attention: \_\_\_\_\_  
103 Superior Drive  
Spring Lake, NC 28390  
910-497-3200  
[sldg3200@embarqmail.com](mailto:sldg3200@embarqmail.com)

Thank you,

\_\_\_\_\_ (Signature) \_\_\_\_\_ (Date)