Morrison Dental Group

CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____

Provider:

Morrison Dental Group
13860 Raised Antler Circle
Midlothian, VA 23112
(804) 739-6163 / (804) 639-7500

Information or Records to be disclosed: _____

Please disclose health information and send records to:

Name: _____

Address: _____

Fax Number: _____ Phone Number: _____

As the person signing this consent, I understand that I am giving my permission to the above named provider for disclosure of confidential health care records.

Signature of Patient: _____ Date: _____