Morrison Dental Group
FAMILY OWNED AND OPERATED
EST
1992

CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name: _____D.O.B. _____ Date: _____

Current Dental Provider's Name:_____
Provider

Address: _____
Provider

Fax Number: _____ Phone Number: _____
Provider *Provider*

Date of last hygiene care visit:_____

Please disclose all health information and send records to*:
***(Patient:** Please mark the location of your first Morrison Dental Group Appointment)*

Morrison Dental Group
4009 Main Street
Chincoteague, VA 23336
(757) 336-1260, FAX: (757) 336-1262

***Provider:** Please send information to the office that is checked above, or e-mail us at*

chincoteague@morrisondentalgroupva.com

***Patient:** Please submit this form to your current dental healthcare provider's office.*

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.

☐ No I do not have x-rays at any other provider.

Signature of Patient: _____ Date: _____

Internal use only:
Chart #: _____