



## 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  
208 Fox Hill Road  
Hampton, VA 23669  
(757) 850-2100

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

**hampton@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 #: \_\_\_\_\_