Morrison Dental Group

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
1130 Wilkinson Rd.
Richmond, VA 23227
(804) 261-4020, FAX: (804) 261-6839

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

richmond@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 #: ________________