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)

☐ 7151 Richmond Road, Suite 305, Williamsburg, VA 23188 – (757) 258-7778, FAX: (757) 258-5158
☐ 1131 Professional Drive, Williamsburg, VA 23185 – (757) 220-0330, FAX: (757) 220-9067

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

records@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 #: _____