



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 #: _____