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*:

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@morrisondentalgroup.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 #: _____