



## CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Provider:

Morrison Dental Group  
1131 Professional Drive  
Williamsburg, VA 23185  
(757) 220-0330

Information or Records to be disclosed: \_\_\_\_\_

Please disclose health information and send records to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_