Morrison Dental Group

CONSENT TO RELEASE CONFIDENTIAL HEALTH CARE INFORMATION

Patient Name: _____ Date of Birth: _____

Provider:

Morrison Dental Group
7151 Richmond Road, Ste 305
Williamsburg, VA 23188
(757) 258-5185

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: _____