Release for Dental Records

Patient Name: _____

Date of Birth: _____

I hereby give _____(Doctor/office) permission to release all dental records, including x-rays, periodontal charting and photographs to Dr. Kristin Herring.

Patient/Guardian Signature: _____

Date: _____

Please release dental records for the patient listed above to the following address:

Dr. Kristin Herring
1930 Woodridge Drive
Hickory, NC 28602

Or

E-mail: info@kristinherringdds.com