REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned acknowledges their lawful authority to request the release of a patient's record. The undersigned and listed patient has hereby requested the transfer of said records and we hereby, request that you release the following patient's records:

Patient's Name: ______________________________________

DOB: ____

Address: ____

____

The patient hereby signs for release of records.

___________________________	________________________
	Witness
___________________________	________________________
Guardian (if applicable)	Date

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.

J. Michael Williams, DDS
600 Erwin Road
Dunn, North Carolina 28339

We thank you in advance for help and cooperation in this matter.