Dr. J. Michael Williams, DDS

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.

_____ Date: _____

Witness: _____ Date: _____

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

Please Mail to: 600 Erwin Road
Dunn N.C. 28334
Or
Email to: lori@drjmichaelwilliams.com or johnna@drjmichaelwilliams.com

We thank you in advance for help and cooperation in this matter; please feel free to call if you have any questions. (910) 891-5000