SEASIDE DENTAL CENTER

2660 NC Highway 210 East, Suite 103 Hampstead, North Carolina 28443
Tele: 910.541.2155 ~ Fax: 910.541.2174 Email: sdcsurfcity@gmail.com

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

I, _____, authorize _____
(Name of facility releasing records)

_____ _____ _____
(City, State) (Phone Number) (Fax)

to release copies of my dental records with respect to any dental care to,

Seaside Dental Center
2660 NC Hwy 210 E., Suite 103
Hampstead, NC 28443
910.541.2155(phone)
910.541.2174(fax)
sdcsurfcity@gmail.com

I understand that the specific type of information to be disclosed may include a detailed report of examinations, findings, treatments, prognosis, and copies of any/all other records including x-rays, which pertain to me.

I hereby release _____ from all legal responsibility
(Name of facility releasing records)

or legal liability that may rise from the release of such information. I understand that I may revoke this consent at any time, except that action has been taken in reliance upon it and that in any event this consent shall expire ninety (90) days after the date below.

A reproduced copy of this authorization shall be valid as original.

Patient Name: _____ DOB _____
Patient Name: _____ DOB _____
Patient Name: _____ DOB _____

Patient/Parent/Legal Guardian Signature: _____

Please email, if possible, records to us. Our email address is sdcsurfcity@gmail. You can also fax records to 910.541.2174 or mail records to the address above. Thank you!!!!