James H. Wells, D.D.S., P.A.
1284 Newsome Street
Mount Airy, NC 27030
(P)336-789-2929 (F)336-789-4908

Consent For Release Of Dental Records

I,_____, do hereby consent to and authorize

_____

To disclose to James H. Wells D.D.S PA at 1284 Newsome Street, Mt. Airy, NC 27030 information in my dental record, including current and previous dental records from other practices and practitioners, hospitals, and/or clinics which are a part of my dental record.

My date of birth is (month/day/year)_____

This information is strictly for purposes of identification.

Signed_____

Date_____

(If additional consent is necessary from a person authorized to give consent, other than the patient, such as parent, guardian, etc., obtain signature)

Signed_____

Relationship to the patient_____

Please email records to office@mountairydentist.com