RECORDS RELEASE AUTHORIZATION

To: _____

Fax: _____

I hereby authorize and request you to release to/from:

Drs. Richard and Amy Hunt
111 Candlewood Rd.
Rocky Mount, NC 27804

Email: faith@huntdentistry.com
Telephone: (252) 443-2328
Fax: (252) 443-7440

The complete history and records in your possession concerning my dental treatment. All radiographs, periodontal charting and summary of the dental care that I received as a patient in your office would be most helpful and greatly appreciated.

Patient's Name: _____ Date of Birth _____

Address: _____

Signature: _____ Date: _____
(If relative, state relationship)