

CONSENT FOR RELEASE OF DENTAL RECORDS

I, \_\_\_\_\_, do hereby consent to and authorize \_\_\_\_\_ to disclose to **Cuthrell & Mochnick, D.D.S., PA at 1341-B Westgate Center Drive, Winston-Salem, NC 27103** information in my dental record, including current and previous dental records from other practices and practitioners, hospitals, and/or clinics which are part of my dental record. Please include all current x-rays & periodontal charting.

My date of birth is (month/day/year)\_\_\_/\_\_\_/\_\_\_, and my social security number is \_\_\_-\_\_\_-\_\_\_\_\_. 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 a parent or guardian, please sign below.)

Signed: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_

**Information may be mailed to the address above or emailed to**

**[info@winstonsalemdentistry.com](mailto:info@winstonsalemdentistry.com)**