DATE _____

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

The execution of this form authorizes the release from your practice to the practice of Hometown Dentistry, Ed Weakley, D.D.S.

RECORDS REQUESTED FOR:

Patient 1 Name: _____Date of Birth: _____

Patient 2 Name: _____Date of Birth: _____

RECORDS REQUESTED FROM:

Practice Name _____ Phone Number _____

SEND RECORDS TO:

Hometown Dentistry Ed Weakley, D.D.S. 120 Medical Court, Clarksville, TN 37043

Phone: 931.648.8015 Fax: 931.503.1904 Email address: info@edweakleydds.com

I, the below signed, authorize the release of copies of my dental records to the above-indicated dentist or dental practice. I understand the information contained in the records belongs to me. I also understand that these records contain Protected Health Information.

Patient (Parent or Guardian) Signature:

_____Date_____Cell _____