Cuthrell DDS & Mochnick DMD

CONSENT FOR RELEASE OF DENTAL RECORDS

I, _____ Date of Birth:_____

Address:_____

Phone Number:_____

do hereby consent to and authorize:

Practice/Doctor Name:_____

Address:_____

Phone:_____ Fax:_____

to disclose all information in my dental record, including current/previous dental records from other practices and practitioners, hospitals, and/or clinics which are part of my dental records to:

Cuthrell, D.D.S. & Mochnick, D.M.D., PA
1341-B Westgate Center Drive
Winston-Salem, NC 27103

Please include all current x-rays & periodontal charting.

Signed:_____

Date:_____

Relation to Patient:_____

Please Email X-rays To:

☐ robyn.baker@winstonsalemdentistry.com

☐ lela.brewer@winstonsalemdentistry.com