



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:

info@winstonsalem dentistry.com