Jason L. Webb, D.D.S
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(706) 935-2211

RECORDS RELEASE FORM

I, _____ hereby authorize
(patient or guardian)
Dr._____

to provide _____with copies of
(party to whom the records will be sent)

my dental records with respect to any dental care and treatment.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, findings, treatments, prognosis and copies of any and all other records, including x-rays, which pertain to me.

This consent is effective until such date as I can cancel this consent. I understand that information obtained as a result of this consent may be used after the cancellation date.

Signed:_____
(patient)

Signed:_____
(parent, legal guardian, or custodian of the patient if the patient is less than 18 years old)

Date _____

Records to be sent to following address:

_____
(Street)

_____
(City) (State) (Zip)