ROBERT L. EDWARDS, DDS, PLLC
2830 MAPLEWOOD AVE, SUITE B
WINSTON SALEM N.C. 27103

MEDICAL / DENTAL RECORDS RELEASE AUTHORIZATION

I, _____, hereby authorize Dr. _____

(Patient name)

to release copies of my treatment records and any radiographs to the doctor's office listed above, or to my insurance company and/or other necessary parties.

I understand that these records and x-rays will be used for treatment purposes, or for claims processing and/or benefit disbursement.

Please forward all information to the address listed above. Thank you for your prompt response.

_____ _____

Patient Signature Date

_____ _____

Patient or Guardian Name (if Patient is a Minor)

_____

Radiographs may be emailed to: robertedwardsdds@gmail.com

Reset Form | Print form | Save As ...*

***Your option! - Save this file, then email it to 'robertedwardsdds@gmail.com'**