CONSENT FOR RELEASE OF DENTAL RECORDS

I, _____, do hereby consent to authorize Dr. Paula M. Stapleton to

DISCLOSE RECORDS TO or OBTAIN RECORDS FROM *(circle one)* :

Name:_____

Address:_____

City/State/Zip:_____

Email Address:_____

Information in my dental record, including current and previous dental records from other practices and practitioners, hospitals, and/or clinics which are part of my dental record.

My date of birth is:____/____/____

**This information is strictly for purposes of identification.

Signed: _____

Date:_____

If additional consent is necessary from a person authorized to give consent, other than the patient, such as parent, guardian, etc., please sign below.

Signed: _____

Date: _____

Relationship to Patient: _____

P# 919.851.6161 F# 919.851.6188

E-mail: info@stapletondentistry.com