James H. Wells, D.D.S., P.A.

1284 Newsome Street
Mt. Airy, N.C. 27030
(336) 789-2929

Consent For Release Of Dental Records

I,_____, do hereby consent to & authorize_____
(Patient's Name) (Previous Dental Practice)

to disclose information in my current dental record and from my previous dental practices, practitioners, hospitals, and/or clinics which are a part of my dental record to the address or email below:

James H. Wells, D.D.S., P.A.
1284 Newsome Street **OR** email Wrighte060@gmail.com
Mount Airy, N.C. 27030

My date of birth is (month/day/year)_____, and my social security number is:

_____-_____-_____. This information is strictly for purposes of identification.

Patient's Signature:_____ Date:_____

(If additional consent is necessary from a person authorized to give consent, other than the patient, such as parent, guardian, etc., obtain signature)

Signed:_____ Date:_____

Relationship to the patient:_____