Consent to Release Records

Patient Information Date: _____

Name * _____

Address: _____

_____ Phone _____

I, _____ hereby authorize **C. Michael Willock, DDS, PA**

To provide _____ with a copy of my health care records and/or any X-rays.

Please check information desired: ☐ X-Rays ☐ Records

Name of any other person authorized to inspect or receive this information:

_____ Relationship _____

Signed: _____ Date _____

Signed: _____ Date _____

Name and address of party to whom records are to be sent:

_____

_____

Any other name that the patient may be listed as: _____

We value you as a patient as a patient and have appreciated the opportunity to serve you. It would be most helpful to us to know why you are transferring so that we can better serve our current patients. Please check the comment that best describes your reason for transfer, or please write your comments.

☐ Moving ☐ Insurance ☐ Financial ☐ Staff ☐ Hours ☐ Other

Comments: _____

_____

Thank you very much, it has been our pleasure to be one of your health care providers. Please feel free to call on us if we can be of service to you again. We wish you the very best of health & happiness. Also, know that if the time comes that you would like to return to this office as a patient, we will feel honored.

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