



6135 Hwy 16 South – PO Box 1005 – Denver, NC 28037
(704) 483-4159 Phone – (704) 483-6669 Fax
Email: office@collinsfamilydentistrync.com

Authorization For Release Of Dental Records

I hereby authorize Dr. _____ to release copies of the dental records and/or x-rays of:

Patient: _____ DOB: _____

Patient: _____ DOB: _____

Patient: _____ DOB: _____

Patient: _____ DOB: _____

To: Ashley M. Collins, DDS, PA
PO Box 1005, Denver, NC 28037

Or email digital x-rays to: office@collinsfamilydentistrync.com

Signed Patient/Guardian

Date

Printed Name – Patient/Guardian