

RECORDS RELEASE REQUEST

Date _____

To _____
(Dentist's Name)

Address _____

City _____ State _____ Zip _____

I authorize the release of dental records and medical records relevant to dental treatment, or copies of such, and request that they be transferred to:

Lynn M. Godwin, D.D.S.
George I. Miller, D.D.S.

301 Keisler Dr., Suite B --- Cary, NC 27511
Telephone: (919) 854-4344

Print Name of Patient

Signature (patient, parent, or guardian)

**PLEASE SEND/TAKE TO YOUR PREVIOUS
DENTAL OFFICE**