

**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)