Stewart Wignall, DDS, PA
Family and Restorative Dentistry

AUTHORIZATION TO RELEASE DENTAL INFORMATION

(The execution of this form does not authorize the release of information other than that specifically described below)

TO:_____

RELEASE TO: Dr. Stewart P. Wignall, DDS
1502 E. Franklin Street Chapel Hill, NC 27514
(P) 919-942-8880 (F) (919) 942-5961 (E) tbrown@chapelhilldentist.com

Patient Name:_____ DOB:_____

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes the following information:

INFORMATION REQUESTED:

___ Copy of complete dental chart

___ Copy of dental x-rays

___ Other (e.g. models· describe)

_____

DATES COVERED:

___All treatment rendered in this office or by this dentist

___Limited to treatment dates for conditions described below:

_____

_____

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

___ Transfer of records

___Second Opinion

___ Other _____

AUTHORIZATION*: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure, but in any event: on_____(date supplied by patient); or_____if revoked in writing by patient; or_____180 days from the date hereof; or____under the following conditions:* _____

_____

OTHER CONDITIONS: A copy of this authorization or my signature thereon: may use with the same effectiveness as an original.

_____
PATIENT NAME (print)

PERSON AUTHORIZED TO SIGN FOR PATIENT:

_____

_____
PATIENT SIGNATURE

DATE_____