ROLLING HILLS DENTAL - RECORDS RELEASE AUTHORIZATION

Date: ___________

ATTN [Practice Name]: ____

[Street or P.O. box address]: ____

[City, State ZIP code]: ____

To Whom It May Concern:

I hereby give my permission to release all of my dental records, including x-rays, to:

Rolling Hills Dental
2625 Old Niles Ferry Road
Maryville, TN 37803
(865) 983-4444
care@rhdsmiles.com

Thank you,

Sincerely,

Patient Name (PRINTED): ____________________________________

Patient Signature: ____________________________________