MEDICAL RECORDS RELEASE

Please fill out the following information for the medical office or individual that you would like to receive your medical records from, or that we can discuss your treatment or payment of your treatment. By signing this form, you give permission to our office to release or obtain your medical records:

Dentist Name: _____

Address: _____

Phone: _____

Email: _____

Please contact us at the following contact information with any questions:

Expertise Dental by Dr. Amanda Seay D.D.S.
3404 Salterbeck Street, Suite 202
Mt. Pleasant, SC 29466
843-375-0395

mpoffice@expertisedental.com

Print Full Name: _____

Date of Birth: _____

Signature: _____ **Date:**_____
(Patient or Parent/Legal Guardian)