



Sandra E. Martin, DMD
General Dentistry
610 Dr. Calvin Jones Hwy #112
Wake Forest, NC 27587

I, _____ hereby authorize

Dr. _____

(Street) _____

(City, State, Zip) _____

(Phone) _____

to release any and all dental records to:

Sandra E. Martin, DMD
610 Dr. Calvin Jones Highway, #112
Wake Forest, NC 27587
Phone 919.488.3384
Fax: 919.488.3385
Email: info@smartindmd.com

This authority to release includes, but is not limited to: dental reports, clinical notes, doctor's notes, subjective and objective complaints, radiographs, any pertinent medical information, interpretations of a diagnostic test (including a copy of the report), diagnosis and prognosis, progress notes, prescription history, and any other document records or information in your possession relative to my past, present and future dental condition.

The records to be sent are for the following family members:

Full name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

This authorization to release the information on the above named patient(s) is subject to the following statement. State law prohibits you from making further disclosure of such information without specific written consent of the person(s) to whom the information pertains or is otherwise permitted by state law.

Signature _____ Date _____

Street Address _____

City, State, Zip _____

Phone Number _____