**Haley G. Mann, DDS / Jordan S. Scott, DMD**

**Cory S. Kuyk, DMD**

**1415 Patton Ave, Asheville, NC 28806**

**Phone (828) 254-9692 Fax (828) 259-9189**

[**www.westashevilledentist.com**](http://www.westashevilledentist.com) **· office@westashevilledentist.com**

Patient: DOB:

**□ Request Release of Dental Records to Drs. Mann, Scott & Kuyk.**

**Please email to: office@westashevilledentist.com**

Who may we contact to obtain your records?

Dr.

Phone #: Fax:

Email:

**□ Release of Dental Records from Drs. Mann, Scott & Kuyk:**

I request the release of my dental records / x-rays to:

Dr.

Address:

Phone #:

Email: Fax:

Patient Signature: Date:

If guardian to patient, state relationship:

**Patient Rights:**

* I have the right to revoke this authorization at any time.
* I may inspect or copy the protected health information to be disclosed as described in this document.
* Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
* Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
* I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

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