**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**

Patient:_______________________________________________ DOB:_________________________

## □ Request Release of Dental Records to Drs. Mann, Scott & Kuyk. Please email to: office@pattonhousedentistry.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.