Request for Records to Be Released From:

Atlantic Dental Group
1301 Physicians Drive
Wilmington, NC 28401
Phone: 910-762-0958
Fax: 910-762-2771

To Whom It May Concern:

I hereby authorize the release of any dental records and x-rays from the office of Dr. Frazelle, Dr. Lee and Dr. Winneberger of Atlantic Dental Group to be sent to:

Name of New Dentist: ____

Address: ____

Phone Number: ______________________ Fax Number: ______________________

Email: ____

Patient Name (Please Print): ____

Patient Date of Birth: ____

____

Patient / Guardian Signature Date