



QC SOUTH DENTISTRY

CONSENT TO RELEASE INFORMATION

Thank you for completing this records request. All requests for records transfers to or from another provider or for your own files will be completed within seven (7) business days from receipt of the request.

Patient's first name: _____ MI: ____ Last name: _____

Date of birth MM/DD/YYYY: _____ Patient's phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Reason for records transfer: _____

I request that the records requested below be transferred to:

Name of office/person to receive the records: QC South Dentistry

Address: 11210 Golf Links Dr N, Ste 201. Charlotte, NC 28277

Phone: (704)-909-2366

I request that the records requested below be transferred from:

Name of office/person to receive the records: _____

Address: _____

Phone: _____

I request that copies of the following dental records are transferred:

Current radiographs only (panorex within five years and bitewings/periapical films within one year)

Print name of patient or guardian

Relationship to patient

Signature of patient or guardian

Date MM/DD/YYYY