VIRGINIA PENINSULA COMMUNITY COLLEGE

DENTAL HYGIENE CLINIC
AUTHORIZATION FOR RELEASE OF DENTAL RECORDS AND/OR DENTAL X-RAYS

I, _____, hereby authorize Thomas Nelson Community College Dental Hygiene Clinic to release copies of my dental records and/or knowledge concerning my medical/dental health and/or dental x-rays for the purpose of patient care to:

Dr's. Name: _____

Address: _____

City, State: _____

Zip Code: _____

Telephone: _____

I specifically request that you release copies of:

_____ Medical/Dental History including Medical Consults if applicable.

_____ Dental Record (Extra/Intra Oral Assessment, Hard Tissue Assessment, Periodontal Assessment, Treatment Plan, Plaque Index, Referral for Dental Treatment)

_____ Dental X-Rays :_____

Patient's Name: _____
(Please Print)
Patient's Signature: _____

Date: _____

FOR OFFICE USE ONLY

Date request for patient records received on: _____

Date patient records sent on: _____