Paul Crandall, DMD, PA
16633 Birkdale Commons Pkwy
Suite 160
Huntersville, NC 28078
Phone 704-892-7488
Fax 704-892-3292

MEDICAL / DENTAL RECORD INFORMATION RELEASE

Section 1: Personal Information

Name: _____ Date of Birth: _____
Last First Middle

Name: _____ Date of Birth: _____
Last First Middle

Daytime Phone #: _____

Section2: Release Information

Today's Date: _____ Date Records Needed: _____

Information to be released: _____ Entire Record

_____ X Rays

_____ Other (Describe) _____

_____

Medical/Dental Records are to be sent to (check one):

Paul Crandall, DMD, PA _____ Released to:

_____

16633 Birkdale Commons Pkwy _____ _____
Suite 160 _____
Huntersville, NC 28078 _____

Section 3: Authorization for Release

I request that Dr_____(phone #)_____release my medical/dental records with the stipulation that the released information be confidential. This information should be forwarded to the location provided above. I understand that this authorization is revocable unless action has already been taken and that unless revoked, it is valid for 90days. **I specifically request the release of alcohol, drug, psychiatric and psychological records, information relating to pregnancy, sexually transmitted disease, HIV testing, AIDS, AIDS-related syndromes, reports concerning cancer, cancer testing, and cancer results.**

_____ _____
Signature **Date**