TRIANGLE ENDODONTICS

Endodontic Records

RELEASE FORM

Per Triangle Endodontics, HIPPA privacy policies, I authorize the release of all of my endodontic reports, digital imaging, and/or pre-operative/ post operative X-rays, as follows:

_____ _____ _____

Patient First Name **Patient Last Name** **Date Of Birth**

Please release the above endodontic records to:

_____

Release to

_____

Address

_____ _____ _____

City State Zip

_____ _____

Phone Number Fax Number

AUTHORIZATION: I request and authorize Triangle Endodontics to release the information specified above to the organization, agency or individual named on this request. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

Please fax the completed form above to our patient records department Fax (919) 887-1407 for processing.

****Per state law, processing time for records release is within 30 days from the date of receipt of the above signed form. Record duplication fee will be billed to the patient as allowed by law.***

*****The above Endodontic records have already been shared with your referring dentist of record (your primary general dentist) and should already be included in your main chart at their office.***