RECORDS RELEASE REQUEST

To _____
Previous Dentist

Address _____

City _____ State _____ Zip _____

Phone #_____ Fax_____

I authorize the release of my FMX/Panorex within 3 years, bitewing Xrays within 1 year, patient history and ask they be transferred to:

Carolina Dental Center
Kevin R. Hojnowski, DMD

767 Wachesaw Road
Murrells Inlet, SC 29576
(843) 357-2122
(843) 357-2124 fax

Email: carolinadentalcenter767@gmail.com

_____
Patient Printed Name

_____
Patient Signature Date