I (we) do hereby authorize **Morse & Doyle, DDS,PA** to release copies of dental x-rays of the person(s) named below to the dentist/physician indicated below. The American Dental Association requires that our office keep on file the original x-rays for a period of 10 years from the date they were taken.

Complete the information below. If the records are for a minor or if you are a guardian for a patient then the parent of guardian should sign the request. Each patient 18 years and older is required to sign for transfer of their records.

Name **Date of Birth** **Signature**

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Send records to:

Dentist Name: ____

Email (we can email most records) ___________________________________

Address: ____

City: __________________________State:______________Zip:_____________

Phone: _______________________ Fax: ________________________________

Please return this form to:

Morse & Doyle, DDS,PA

633 Hopkins Road

Kernersville, NC 27284

Office # 336-996-4400 or Fax 336-996-4401

appointments@morsedoyle.com