I (we) do hereby authorize _____

to release copies of dental x-rays of the person(s) named below to

Morse & Doyle, DDS, PA

Complete the information below. If the records are for a minor or if you are a guardian for a patient then the parent or 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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Please send records to:

Morse, Doyle, DDS & Associates
633 Hopkins Road
Kernersville, N.C. 27284
336-996-4400
Fax 336-996-4401

Please email digital x-rays to patientinfo@morsedoyle.com