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 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**

Send records to:

Dentist Name:_____

Email (we can email most records):_____

Address:_____

City:_____ St_____ Zip_____

Phone:_____ Fax:_____

Please return this form to:

Morse, Doyle, DDS & Associates
633 Hopkins Road
Kernersville, N.C. 27284

patientinfo@morsedoyle.com