JEFFREY J. TIBBS, D.D.S., P.A.
3455 HEALY DRIVE
WINSTON-SALEM, NC 27103
TELEPHONE: 336-765-7477

AUTHORIZATION TO RELEASE MEDICAL/DENTAL RECORDS

I hereby authorize _____ to
(Name of Dental Office)

release the records of _____.
(Name of Patient)

Please transfer the records, or copies of the records, to the following address:

Email: manager@tibbsdental.com

Jeffrey J. Tibbs, D.D.S., P.A.
Medical Records – Release of Information
3455 Healy Drive
Winston-Salem, NC 27103

Patient's Name: _____

DOB: _____ Social Security #: _____

Parent / Guardian: _____
(Please print name)

I agree to release _____ from any liability
(Name of Dental Office)

that may occur as a result of transferring these records.

Signature: _____ Date: _____