



Dental Record Release Form

I authorize the release of current radiographs and dental records to be sent to:

Carolina Dentistry
2329 Devine Street, STE 2
Columbia, SC 29205
Telephone: (803) 799-3368
Fax: (803) 799-3504
Email: office@carolinadentistrysc.com

I authorize Carolina Dentistry to release my records to:

Office Name: _____

Phone Number: _____

Email: _____

Patient Name (Printed): _____

DOB: _____

Patient, Parent, or Guardian Signature: _____

Date: _____