Patient/Guardian - Please complete this form and mail/fax to your previous dentist – Thank you!!

Request for release of dental records

Jason E. Martin, DDS
236 Market Street, Suite 200
Locust, NC 28097
www.jmartindental.com
Phone: 704-781-0500 * Fax: 704-781-0555

I, _____, hereby grant permission to
(Print patient name)
_____ to release information related to my dental health, which may include, but not limited to:
Copy of Dental X-Rays
Treatment Records/Notes

****For digital x-rays please email to: info@jmartindental.com**
Dr's office personnel: please return this form and records directly to:

Jason E. Martin, DDS
236 Market Street, Suite 200
Locust, NC 28097

Signature: _____ **Date:** _____
(*If patient is a minor, parent or guardian must sign*)