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**RELEASE OF PATIENT RECORD INFORMATION
(THIS FORM MUST BE COMPLETED IN FULL)**

Name of Patient: _____

Address of Patient: _____

Number & Street City State Zip Code

Social Security #: _____ Date of Birth: _____
month day year

I hereby authorize _____
(Name of doctor, hospital, or dental school RELEASING information)

To RELEASE TO: _____
(Name of doctor, hospital, dental school, or individual to RECEIVE information)

The following information: _____

Covering the period of care from _____ to _____

I understand that this information will be used for _____

I further understand I may revoke this consent at any time except to the extent that action has already been taken on it and that it will expire automatically ninety (90) days from the date below.

The doctor, hospital, or dental school releasing authorized information is hereby relieved from all legal responsibility or liability for the release of the information described above to the extent indicated and authorized herein.

_____ Date

_____ Signature of Patient

If the patient is a minor or is unable to give permission to sign the foregoing because of physical disability or mental incompetence, complete the following: The patient is unable to consent or sign the foregoing because _____

Signature of Patient's Representative _____

Relationship to Patient _____

Form faxed/mailed date _____ office called for followup date _____