Mary Makhlouf, DMD, MS, PA
1682 Westbrook Avenue
Burlington, NC 27215
336-226-8406

AUTHORIZATION FOR RELEASE OF MEDICAL & DENTAL RECORDS

PATIENT IDENTIFICATION:

Name: _____
First Middle Last Maiden

Date of Birth: _____ Social Security #: _____

Source of Information:
Name of Physician(s), Dentist(s), Facility or Hospital:

_____

Address/Phone/Fax:

Receiver of Information: Mary Makhlouf, DMD, MS
1682 Westbrook Avenue
Burlington, NC 27215
Phone: 336-226-8406
Fax: 336-226-9281

Information Requested:

___ Latest H&P
___ Latest list of medications
___ Labs:_____
___ Operative Reports
___ Radiation Oncology PORTS and Doses
___ Medical Progress Notes
___ Any available X-rays
___ Any available dental casts
___ Dental Progress Notes
___ Dental Treatment Plans
___ Other:

AUTHORIZATON:
I authorize and request the "Source of Information" listed above to release to the "Receiver of Information" listed above, information pertaining to any and all treatment as checked above (this includes information pertaining to mental health, immune deficiencies or drug and alcohol abuse diagnoses). The purpose for the release is to assist in a comprehensive evaluation and treatment planning.
I understand that I may revoke this consent at any time. If I choose to do so, I will inform Dr. Mary Makhlouf in writing. This hereby releases the sender from all the legal responsibility or liability of the release of the information from my records, described above.

SIGNATURE _____ _____
(Patient or Authorized Representative) (Relationship if other than Patient)

WITNESS_____ DATE_____