Bull City Smiles
Debora Bolton, D.D.S., P. A. and Associates
2705 N. Duke St. Suite 100
Durham, N.C. 27704
(919) 381-5900 phone
(919) 222-08775
appointments@BullCitySmiles.com
www.BullCitySmiles.com

Records Release Request

Patient's Name:_____ **Date of Birth** _____

I hereby authorize the release of my dental records or copies of such:

Clinical Notes and X-Ray Film(s) for the last 2 years

To be sent: from the office of Bull City Smiles.

Office/ Doctor's Name: _____

Special Request: If possible, please *Email Digital X-rays in .jpeg format and chart note as .PDF*

- You have the right to obtain a copy of your medical records. The law requires a **signed authorization form** which contains certain criteria included on this form. This form must be **fully completed** before any medical information can be released.
- I understand this Authorization can be revoked at any time according to Willowdaile Family Dentistry's Notice of Privacy Practices. This request must be made in writing and sent to the same place that the original request was made. Attach a copy of this release.
- Treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization.
- The facility, its employees and officers, and attending physician(s) are released from legal responsibility or liability for release of the above information to the extent indicated and authorized.
- If you would like to pick up your records, indicate this on the form with a phone number where you can be contacted. Otherwise, records will be mailed to the address listed on the authorization, or may be e-mailed for easy upload by another dentist if they are digital.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

_____ _____

Date Signature of Patient

If patient is unable to sign, secure consent of
legal representative and indicate reason below:
☐ Minor ☐ Incompetent ☐ Deceased

_____

Signature of Legal Representative and Relationship to Patient