Dan K. Dube, D.M.D.

5653 Carolina Beach Dr., Suite C1
Wilmington, NC 28412
Phone: (910)791-0986
Fax: (910)791-2902

Consent from Patient for Release of Dental Information & Records

Instructions:
Please complete this form and we will mail or fax records to your new dentist.

I hereby authorize you to send a copy of the dental records, including all progress notes and radiographs for: _____ (Patient's name)**

To the office of Daniel K. Dube, DDS, PA from the office of: _____ at _____.

I release you from all legal responsibility or liability that may arise from this authorization.

Thank you.

_____ _____

Signature of Patient, Parent or Legal Guardian Date

**Please list names of all family members and their date of birth if they are to be sent also.

Please email back to info@dandubedentistry.com