Request for Records to Be Released To:

Atlantic Dental Group
1301 Physicians Drive
Wilmington, NC 28401
Phone: 910-762-0958
Fax: 910-762-2771

Name of Prior Dentist: _____

Contact Information: _____

Phone Number: _____ Fax Number: _____

Email: _____

To Whom It May Concern:

I hereby authorize the release of any dental records and x-rays to the office of Dr. Frazelle, Dr. Lee, Dr. Pless and Dr. Paterson of Atlantic Dental Group.

Patient Name: _____

Patient Date of Birth: _____

_____
Patient / Guardian Signature Date

Please Note:

Email is the preferred method of receiving x-rays.
Please send the images in Dexis format (.dex) or JPEG (.jpg) to: RECORDS@Atlantic-Dental.com
or mail them to the address noted above. Please include the date the x-rays were taken. Thank you.