
**Authorization to Release Patient Records to Augusta University School of Dental Medicine**

Patient Name: _____Date: _____

Account #:_____

Doctor Name:_____

Doctor Address:_____

I hereby state that I have requested the release of the medical x-ray films and/or other records of Patient Name: _____which are currently the part of the patient records files held by Whitefoord, Inc. Dental Clinics.

I, Patient Name: _____, release my dental records to Augusta University School of Dentistry authorizing the students and faculty to use for educational and treatment purposes.

I acknowledge the receipt of the aforementioned records and associated documents, and I fully discharge Meridian Education Resource Group dba Whitefoord, Inc. and Augusta University School of Dental Medicine from any liability that may arise as a consequence of their release.

Signature: _____

Printed Name:_____

Witnessed By:_____

Printed Name: _____