Records Release Request Form

I, ___________________________,

__________________________,
(Date of birth)

Hereby authorize:
Kendalyn Lutz-Craver, DDS, PA
101 Life Enrichment Blvd.
Shelby, NC 28150

To release dental xrays or copies of such as follows:
Bitewings and periapical xrays taken within the past year, panoramic or full mouth series taken within the past 5 years to the following office:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address above. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

This authorization shall be in force and effect until the requested items have been delivered or the information has been reviewed by the patient.

Signed____________________________________Date_____________