

**RECORDS RELEASE REQUEST**

To \_\_\_\_\_  
Dentist/Doctor/Hospital

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I authorize the release of my \_\_\_\_\_

or copies of such and ask they be transferred to:

**Carolina Dental Center  
R. Jason Meares, D.D.S., P.A.**

**P.O. Box 602  
Murrells Inlet, SC 29576  
(843) 357-2122  
(843) 357-2124 fax**

\_\_\_\_\_  
Print name of Patient

\_\_\_\_\_  
Date of Records

\_\_\_\_\_  
Patient's Signature Date