Phone: 865-637-5708
Fax: 865-637-5712

Medical Release Form

Patient Name ______________________________ Date of Birth ______/______/______

I, __________________________________ hereby authorize the doctor and staff of Premier Dental
(Patient's Name or Parent / Legal Guardian)
Group, PLLC of Knoxville to release records concerning my dental health. I understand that the specific type of information disclosed may include a detailed report of examinations, treatment provided, x-rays and other records that pertain to my dental information.

Please select one:
____ 1. Records given directly to me (or parent / legal guardian, if patient is a minor)
____ 2. Records to be sent to other dental office (complete below)

Name of Dental Practice / Dentist: ____

Address: ____

City: _________________________ State: _________________ Zip Code: ___________

Telephone Number: ____

Email Address: ____

PRINT Patient Name: ____

SIGN Patient Name: ____ Date: _____________
(If minor, signature of Parent or Legal Guardian)

Signature of Premier Dental Group, PLLC of Knoxville Witness: ________________________________

Date: __________________________

Premier Dental Group, PLLC of Knoxville
303 South Concord Street, Suite 323
Knoxville, TN 37919