<u>Consent for Release of Dental Records</u>

I, _________________________________, date of birth ___________

hereby consent to and authorize

____to ***disclose*** to

Dr. W. Stephen Coker, DMD, PA
Parkway Dental 3600 NW Cary Pkwy, Ste. 115, Cary NC 27513.
(Digital xrays may be emailed to info@wscoker.com)

information in my dental record, including current and previous dental records from other practices, hospitals, and/or clinics which are a part of my dental record.

This information is to be kept confidential and used solely for purposes of identification.

Patient/Parent/Guardian signature ____________________________Date __________

Relationship to Patient ________________

07/15