Timothy D. Wiley, D.M.D.
1001 Gibson Bay Drive, Suite 202
Richmond, KY 40475
Office: 859-625-0204 Fax: 859-625-5223

Authorization for Release of Dental/Medical Records

I, ____________________________________Date of Birth _______________,

do hereby authorize Dr.____

to release copies of any and all medical records and radiographs. This is to include without limitation, any personal, confidential information of a sensitive nature or information pertaining to communicable diseases such as HIV, Hepatitis, etc. Any and all information that would be of assistance to the doctor and staff are requested.

Copies are to be released to:

Highland Dental
Timothy D. Wiley, D.M.D.
1001 Gibson Bay Drive, Suite 202
Richmond, KY 40475

*Radiographs/x-rays may be e-mailed to: timothydwileydmd@gmail.com
*If no e-mail capability, radiographs/x-rays need to be copied onto photo paper.

By signing below, I am authorizing the release of my Dental/Medical records:

Patient's Name/Legal Guardian (printed): ______________________________

Patient's/Legal Guardian's Signature: ________________________________

Date: _______________