PRETTYMAN ORTHODONTICS

# Medical Records Release Authorization Form

I, _____, would like to request to have copies of my treatment records and any necessary radiographs (X-rays) sent to the email address, street address, or to my insurance company and/or any other necessary parties listed below.

*If the purpose of this record release is to obtain a hard copy of your treatment record and you are requesting your records to be mailed to you or you are picking them up from the office, please understand that it may require 30 days for your records to become available.

To transfer radiographs/photos/records **FROM** our office, please:

Email to: _____

Mail to:

Name: _____

Address: _____

City/State/Zip: _____

To transfer radiographs/photos/records **TO** our office, please:

Email to: xraysouthparkortho@prettymanorthodontics.com

Mail to: Prettyman Orthodontics – SouthPark
5970 Fairview Road, Suite 150
Charlotte, NC 28210
704-247-9150

Patient Name (Print):

Parent/Guardian Name & Signature: Date:

Terrence Campbell, DMD, MS
*Orthodontist*
Gastonia: 704-247-9121
Monroe: 704-247-9120
www.PrettymanOrthodontics.com