



Records Release Form

Patient Name: _____

Date of Birth: _____

*By signing this document, I hereby authorize the release of my dental records from _____
_____ to **Wiggs Family
Dentistry** located at 7509 Six Forks Road in Raleigh, NC.*

Prior Office Telephone Number: _____

Patient Signature (for individual records): _____

Guardian Signature (*family records and children*): _____

Today's Date: _____

Please email all records to our office email at wiggfamilydentistry@yahoo.com. Thank you!

Wiggs Family Dentistry
7509 Six Forks Road. Suite 201
Raleigh, NC 27615
(919)-847-5955