# Smiles By Shaw

**Dr. Chelsea Marcuard, DDS**
**Dr. Shannon Minges, DMD, MPH**

## Authorization to Release Patient Records

**Patient Name:** _____ **DOB:** _____ **Phone:** _____

**If more than one patient;**

**Name:** _____ **DOB:** _____ **Phone:** _____

**Name:** _____ **DOB:** _____ **Phone:** _____

**Dentist or Practice Name:** _____

**Address:** _____ **City/State/Zip:** _____

**Phone:** _____ **Fax:** _____ **Email:** _____

You are hereby requested and authorized to release all Protected Health Information in the form(s) of **Records, Radiographs, and Treatment Notes** or other information concerning the patient(s) listed above to: **Smiles By Shaw.**

_____ **Date:** _____

**(Patient Signature/Legal Guardian)**

Please mail to: Dr. Marcuard & Dr. Minges
1100 Professional Drive
Greenville, NC 27858

-or-

If records are digital, please email to:
shawgreenville@centurylink.net
Office Contact Number: (252)-355-7429
Office Fax Number (252)-355-4582