



Evan G. Long, DDS,
PA
Pediatric Dentistry

Please release dental record for the names listed below:

Reason for transfer (optional):

Mail To:

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

Parent's Signature

Date

5641 Poplar Tent RD Concord, NC 28027 Fax 704-7952301 PH 704-795-2300