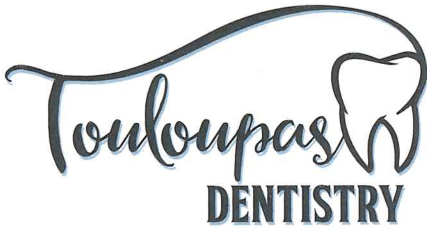

1628 MEMORIAL DRIVE • SUITE B • BURLINGTON, NC 27215 • (336) 226-5485 • FAX (336) 226-5435 • WWW.NCSMILE.COM

MICHAEL J. TOULOUPAS, D.D.S.
CYNTHIA K. TOULOUPAS, D.D.S., M.P.H.

Consent Form for Release of Current Dental Records

Please email records to office@ncsmile.com or kerrie@ncsmile.com
or mail hard copies to 1628 Memorial Drive, Suite B,
Burlington, NC, 27215

I, ______________________________ do hereby consent to and authorize ______________________________ to disclose to Touloupas & Touloupas Dentistry the information in my dental records as follows:

_____ x-rays taken in the last 24 months (including bitewing x-rays, periapicals, FMX, and panorex)

_____ Treatment Notes _____ Perio Charting _____ Other

Patient's home address is ______________________________

Patient's date of birth is ________________

Patient's Signature______________________________ Date ____________

Patient's Printed Name ______________________________

Parent or Guardian's Signature (if under 18) ______________________________

Parent or Guardian's Printed Name ______________________________ Date ____________

This authorization shall remain in effect until the information has been forwarded as requested.

I understand that my treatment will now be conditioned on signing this authorization and that I have the right to refuse to sign the authorization. I understand that information disclosed as a result of this authorization may be subject to re-disclosure 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 above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to Touloupas & Touloupas Dentistry.