

JEFFREY J. TIBBS, D.D.S., P.A.  
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**AUTHORIZATION TO RELEASE MEDICAL/DENTAL RECORDS**

I hereby authorize \_\_\_\_\_ to  
(Name of Dental Office)

release the records of \_\_\_\_\_.  
(Name of Patient)

Please transfer the records, or copies of the records, to the following address:

**Email: [manager@tibbsdental.com](mailto:manager@tibbsdental.com)**

**Jeffrey J. Tibbs, D.D.S., P.A.  
Medical Records – Release of Information  
3455 Healy Drive  
Winston-Salem, NC 27103**

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_  
(Please print name)

I agree to release \_\_\_\_\_ from any liability  
(Name of Dental Office)

that may occur as a result of transferring these records.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_