Timothy G. Wilson, D.D.S., P.C.

Consent to release records

This is a letter of consent to furnish and release my dental records including patient treatment chart, periodontal charting, and current X-Rays to Timothy G. Wilson, DDS, P.C. This office is a paperless office so please submit in digital form when possible.

Doctor's name: ____

Phone: __________ Fax: ____________ Email: _________________

City: _________________ State: ____________ Zip: ____________

Patient date of birth: _______________________________________

Patient signature: ____

Patient name printed: _______________________________________

Thank you for your immediate attention,

Timothy G. Wilson, D.D.S., P.C.

Phone: (520) 797-8030

Email to: tgwilsondds@comcast.net