PAUL D. MIGHION, D.D.S.
198 HOSPITAL STREET
MOCKSVILLE, NC 27028

REQUEST FOR RELEASE OF PATIENT RECORDS

The undersigned and listed patient has hereby requested the transfer of said records and we hereby, request that you release the following patient' records:

Patient's Name:
DOB:
Address:

The undersigned acknowledges receipt that they are lawfully authorized to receive said records.

_____ _____
Patient Signature Witness

---------- Date ----------
Guardian (if applicable)

We thank you in advance for help and cooperation in this matter.