Southern Smiles

Request and Authorization to Release Dental Records

Authorization to Release All Dental Records to The Following Doctor:

Name of Doctor(s) Records Will Be Released To:

_____

Patient's Name: _____

Patient Date of Birth: ___/_____/_____

Patient Address: _____

Patient Telephone Number: (_____)_____

Name of Dental Provider/Practice Providing the Records:

_____

Dental Provider Address:_____

Dental Provider Phone Number: (_____)_____

Dental Provider e-mail:_____

I hereby request and authorize the release of all dental records as provided for the above-referenced patient to the above doctors at Southern Smiles of Cary NC.

_____

Printed Name of Parent/Guardian

_____

Signature of Parent/Guardian Signature Date

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