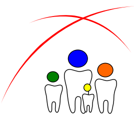

GREAT SMILES DENTAL CARE
610 Professional Dr., Suite 250 • Gaithersburg, MD 20879
Tel: (301) 963-5555
www.GreatSmilesDentalCare.com
Email: info@GreatSmilesDentalCare.com

Authorization for Release of Dental Records

(Please type or print legibly)

I, ____, hereby authorize **Great Smiles Dental Care** to release the following patient's dental records:

Patient's Name ____

Patient's Date of Birth ____

Street Address ____

City _______________________________________ State ___________________ Zip _________________

Tel __________________________ Email ____

To person/organization:

Person's Name ____

Organization's Name ____

Street Address ____

City _______________________________________ State ___________________ Zip ___________________

Tel _________________________ Fax _______________________

Email ____

Patient/Guardian's Name ____

Authorized Signature ____ **Date** ___________________

FOR OFFICE USE ONLY

Date request received ___________________________ Date sent ___________________________

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