GREAT SMILES DENTAL CARE
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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 _____

_____

_____