RELEASE FOR NEW PATIENTS COMING TO OUR PRACTICE

RECORDS RELEASE REQUEST OF HEALTH INFORMATION

Date_____

I, _____, hereby grant permission to my previous dentist, Dr._____, to release my information related to my dental/medical history, status, and treatment along with copies of my records and x-rays to:

Smith Family Dental Solutions
301 Keisler Dr. Suite B
Cary, NC 27518
Telephone: (919) 854-4344
FAX: (919) 854-4340
sue@gfdsmiles.com

I greatly appreciate your assistance in this matter.

_____
Print Name of Patient

_____
Signature (patient, parent, or guardian)

(PLEASE SEND/TAKE TO YOUR PREVIOUS DENTAL OFFICE.)