



General Dentistry for Youth

| first tooth through age 25 |

REQUEST FOR RELEASE OF DENTAL/MEDICAL RECORDS

Today's Date: _____
Previous Dental Office: _____
Fax#: _____
Email: _____

I hereby authorize the release of any dental/medical records your office has for named patients below:

Patient's Name: _____ Patient's Name: _____

DOB: _____ DOB: _____

Patient's Name: _____ Patient's Name: _____

DOB: _____ DOB: _____

Patient's Name: _____ Patient's Name: _____

DOB: _____ DOB: _____

Please transfer the records or copies of the records to the following address:

Smile Starters
655 Lenoir Rhyne Blvd. SE
Hickory, NC 28602

We follow all HIPAA guidelines to protect your health information. If you'd prefer to send the records electronically, please send them in a HIPAA compliant (encrypted) format to the following email address: aomconover@smilestartersdental.com or please contact us to request a free ShareFile® login to use our encryption service.

Parent/Guardian Name: _____

(Parent/Guardian Signature) Date Requested)

Thank you in advance for your prompt response to this request. If you have any questions, please do not hesitate to contact our office.
Office: 828-469-3000 Fax: 828-469-2392 Email: aomconover@smilestartersdental.com