



## 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 DOB \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

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

**Smile Starters  
247 Biltmore Ave.  
Asheville, NC 28801**

We follow all HIPAA guidelines to protect your health information. If you'd prefer to **send the records electronically**, please send them in a HIPPA compliant (encrypted) format to the following email address: **[aomasheville@smilestartersdental.com](mailto:aomasheville@smilestartersdental.com)**

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: 828-350-1076 Fax: 828-350-1636  
Email: [aomasheville@smilestartersdental.com](mailto:aomasheville@smilestartersdental.com)

office 828.350.1076 | fax 828.350.1636  
247 Biltmore Avenue | Asheville, NC 28801

Rafael Rivera, Jr., DDS, PLLC