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
4901 North Tryon Street
Charlotte, NC 28213

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: **aomtryon@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: 704-921-0204 Fax: 704-921-4095 Email: **aomtryon@smilestartersdental.com**