Smile Starters
General Dentistry for Youth
first tooth through age 20

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: _____ DOB: _____

Patient's Name: _____ DOB:_____

Patient's Name: _____ DOB:_____

Please transfer the records or copies of the records to the following address:Smile Starters 2520 N. College Road Wilmington, NC 28405 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: aomwilmington@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: 910-790-3836 Fax: 910-790-5026
Email:aomwilmington@smilestartersdental.com