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: _____ 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
900 Summit Ave.
Greensboro, NC 27405

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: **aomgbro@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: 336-370-1112 Fax: 336-544-0739 Email: **aomgbro@smilestartersdental.com**