Patient Name: _____

Date of Birth _____

Address: _____City_____ State_____ Zip _____

RELEASE FROM LIABLILITY FOR PATIENT ACCESS TO DENTAL RECORDS

I hereby request that:

( ) _____ Smiles Dental

( ) _____

and/or responsible staff release

( ) Copies of X-rays
( ) Clinical Data

Send to: _____

Address: _____City _____ State _____ Zip _____

I am having my records transferred for the following reason:

_____

_____

How records were released: Mailed ___ Hand Delivered ___Emailed ___ Picked up ___

_____

Signature **Date**