Records Release Form

Smiles of Port Orange
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I request the release of any records relevant to dental treatment be transeferred to:

Doctor/Physician: _____

Address: _____ **Apt/Unit:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Email: _____

Name of Patient: _____ **Birthdate:** _____

Name of Patient: _____ **Birthdate:** _____

Name of Patient: _____ **Birthdate:** _____

Records being Requested

- ▢ Current Radiographs
- ▢ Periodontal Charting
- ▢ Photos
- ▢ Specialist Reports
- ▢ Other

Signature Patient or Guardian: _____ **Date:** _____