



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: _____

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Please transfer the records or copies of the records to the following address:

**Smile Starters
3053 Freedom Dr.
Charlotte, NC 28208**

We follow all HIPAA guidelines to protect your health information. If you'd prefer to send the records electronically, please send them in a HIPAA compliant (encrypted) format to the following email address: aomfreedom@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: 704-393-3911 Fax: 704-392-1096 Email: aomfreedom@smilestartersdental.com

office 704.393.3911 | fax 704.392.1096
3053 Freedom Drive | Charlotte, NC 28208

Rafael Rivera, Jr., DDS, PLLC