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
1400 Walter Reed Rd, STE 200
Fayetteville, NC 28304

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: **aomfay@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: 910-864-9884 Fax: 910-354-1399 Email: **aomfay@smilestartersdental.com**