



**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  
508 10<sup>th</sup> Street NW  
Conover, NC 28613**

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: [aomconover@smilestartersdental.com](mailto:aomconover@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: 828-469-3000 Fax: 828-469-2392 Email: [aomconover@smilestartersdental.com](mailto:aomconover@smilestartersdental.com)