PLEASE COMPLETE AND FORWARD TO YOUR PREVIOUS DENTIST

AUTHORIZATION TO RELEASE CONFIDENTIAL

PATIENT INFORMATION

I, _____ request and

authorize the office of _____

Address: _____ Phone #: _____

to release my dental records/information to:

Smile Innovations Dentistry

4110 A Street

Lincoln, NE 68510

402.484.8444 phone

402.484.8445 fax

These records may include: personal patient information, medical and dental history, record of dental examination, radiographs, clinical photographs, reports and models.

Signed: _____ Date_____

Patient/Guardian Name