Austin R. Smith DDS

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Authorization to release Dental Records

I hereby request that a summary of dental care and/or duplicate x-rays be sent to:

_____
_____
_____
_____
Email_____

On the Following patient(s):

_____ DOB_____
_____ DOB_____
_____ DOB_____
_____ DOB_____

Reason(s) for this authorization:

( ) Moving, Going to DDS closer to home
( ) Change of Insurance
( ) Other_____

_____Date:_____
Patient / Parent / Legal Guardian Signature

Additional Comments:

_____
_____