

# Smiles for Life

5724 Hansel Ave. - Orlando FL 32809 - 407-812-7499

## Request for Release of Records

Date: \_\_\_\_\_

I hereby authorize the release of my dental records or copies of such and request that they are transferred to:

To (Doctor or Hospital): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Records: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_