Record Release Form

I (Print Patient's Name _____) hereby authorize (Former Dentist's Name or Dental Office _____) to provide MidTown Smiles Dental Care with copies of my dental records with respect to any dental care and treatment that I have received. I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me. I understand that the information obtained as a result of this consent may be used after the cancellation date.

Previous Office Location: _____

Previous Office Telephone Number: _____

Previous Office Email Address-if available:_____

Patient Date of Birth: _____

Patient or Legal Guardian Signature: _____

Date: _____

Please email all records MidTown Smiles Dental Care info@midtown-smiles.com

OR FAX # 919-787-5548

info@midtown-smiles.com

919-787-5599