DENTAL RECORDS & X-RAYS RELEASE

Nu-Smile Family Dentistry

1657 River Street

Valdosta, Ga 31601

229-244-8884 (office) 229-244-8874 (fax)

PATIENT INFORMATION

NAME_____

ADDRESS_____

CITY, STATE, ZIP CODE_____

DATE OF BIRTH_____

PHONE_____

SEND RECORDS TO: nusmilevaldosta@yahoo.com

SELF/DENTIST_____

ADDRESS_____

CITY, STATE, ZIP CODE_____

PHONE_____FAX_____

I understand that all information I hereby authorize to be obtained will be held strictly confidential and cannot be released without my written consent.

PRINTED NAME_____ DATE_____

(PATIENT/GUARDIAN)

SIGNATURE_____ DATE_____

(PATIENT/GUARDIAN)