DENTAL RECORDS & XRAY RELEASE

NU-SMILE FAMILY DENTISTRY
1657 River St
Valdosta, GA 31601
(229) 244-8884

I, _____, hereby request and give my permission to

Nu-Smile Family Dentistry to provide Dr._____ with any and all information regarding past dental care for:

(Patient Name)_____

(Date of Birth)_____

Such records may include dental history, medical history, consultation, prescriptions, radiographs, models and copies of all dental records and medical records.

Please have these records sent to:

SELF/DENTIST _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

PHONE _____

EMAIL _____

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

PRINTED NAME: _____ Date: _____

SIGNATURE: _____ Date: _____

(Parent, Legal Guardian or Custodian of the Patient, if Patient is a Minor)