DENTAL RECORDS & XRAY RELEASE

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)