RECORDS RELEASE AUTHORIZATION

Smile Center of Orlando
3710 Aloma Avenue
Winter Park, FL 32792
Ph: 407-678-8848 Fx: 407-678-7766

I authorize the Smile Center of Orlando to release (choose options):

_____ any necessary requested information

_____ account history

_____ x-rays only (if you are returning to our office for treatment and do not return the released x-rays by your next appointment, there will be a $10 duplicating fee for BWX & $25 for Pano/Full Mouth Set)

_____ the following _____

TO:
Dental Office: _____

Phone Number: _____

Address: _____

_____

_____

- OR -

Patient Name: _____

Phone Number: _____

Address: _____

_____

_____

Patient Printed Name: _____

Patient Signature: _____

Today's Date: _____

Staff who released records: _____

Note: A faxed image or copy of this authorization shall be deemed as an original.