Records Release Authorization

Patient Name:_____

Birthdate:_____

Address:_____

_____

Phone:_____ Email:_____

☐ I authorize the release of my dental records; X-rays, clinical notes, photos, & charting to:

Middleton Smiles
1064 W Main St
Middleton, Idaho 83644
208-585-9200 Fax: 866-323-0399
frontdesk@middletonsmiles.com

☐ I authorized Middleton Smiles to release and send my records to:

Name of Dentist or Dental office:_____

Address:_____

_____

Phone:_____Fax:_____

Email:_____

Print Name of Patient: _____

Signature (Parent or Guardian): _____

Date: _____