Wake Forest Smiles

1936 Heritage Branch Rd Suite 200

Wake Forest, NC 27587

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AUTHORIZATION TO RELEASE RECORDS AND RADIOGRAPHS

Patient Information: _____

Patient Name: _____

DOB: _____

Address: _____

City, State, Zip code: _____

E-mail address: _____

Additional Family Members:

Name: _____ D.O.B: _____

Name: _____ D.O.B: _____

Name: _____ D.O.B: _____

Name: _____ D.O.B: _____

Name: _____ D.O.B: _____

Practice you would like records released to (if you are requesting records be sent to you, we will e-mail you your records):

Name of Dental Office: _____

Address: _____

Phone #: _____

Fax #: _____

Email: _____

Signature: _____ Date: _____

If you have any additional questions, please feel free to contact us at 919-570-2845.