Smile Connections Family Dental
James A. Volker, D.D.S. and Sara E. Meng, D.D.S.

RECORDS RELEASE

Please use this form to release the records/x-rays from your previous dentist prior to your appointment.

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ D.O.B: _____ Date: _____

I hereby authorize: (previous dentist information)

Dentist Name: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

to release any current diagnostic x-rays (including pano and/or full mouth series) as well as any dates and/or notes regarding Major restorative treatment performed by your office to:

Smile Connections Family Dental
250 N Tyler Rd
WICHITA, KS 67212
316-722-8148
info@smileconnectionsdental.com

Date of last exam ___/___/___ Date of last prophy ___/___/___ Date of last Fluoride ___/___/___

Date of last radiographs, if known and copies if available:

Full mouth series of x-rays Date ___/___/___
Panoramic x-ray Date ___/___/___
Bitewing x-rays Date ___/___/___

Current status of treatment:

Remarks:

The facility, its employees and the attending dentist are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized by this release. I am accepting responsibility for these records and for the protection of my own right of medical record confidentiality.

_____ _____
Signature of Patient Date

_____ _____
Signature of Person Authorized to sign, other than patient Relationship to patient