James A. Volker, D.D.S.
SMILE CONNECTIONS FAMILY DENTAL

James A. Volker, D.D.S.

Records Release Form

PATIENT INFORMATION					
First Name		**Last Name**		**Birth Date**	

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

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

I hereby authorize: (previous dentist information)

Dentist Name: _____

Practice Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

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:

FORM COMPLETION

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.

Responsible Party Signature		**Date**	
Responsible Party Name		**Relationship to Patient**	