Union Smiles
COMPLETE HEALTH DENTISTRY

On this date, _____, I, _____ hereby authorize

_____
(provider/office name)

to release my/my dependent's dental records and all protected health information including treatment completed, summaries of symptoms, prognosis, diagnosis, and treatment notes. Please forward all information to:

Union Smiles
301 Hwy 50W Ste C
Union, MO 63084

Phone: 636-583-8100
Fax: 636-583-6534
Email: ContactUs@UnionMoSmiles.com

_____ _____
Signature Date

_____ _____
Printed Patient Name Date of Birth