Washington 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 note. Please forward all information to:

Washington Smiles
1111 E 6th Street
Washington, MO 63090

Phone: 636-239-6328
Fax: 636-239-5048
Email: ContactUs@WashMoSmiles.com

_____ _____
Signature Date

_____ _____
Printed Patient Name Date of Birth