



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