smilesinc
Dentistry & Maxillofacial Surgery

AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

PATIENT NAME: _____ D.O.B: _____

Address : _____

_____

Phone: _____ Email : _____

Current Dental Office: Smilesinc 12, Dundonald Street Hamilton Bermuda HM 09
Phone: 441 296 0990 Email: smiles@smilesinc.bm

New or Referred to Dental/Medical Office : _____

Address : _____

_____

Phone: _____ Email : _____

I, the undersigned hereby authorize the transfer of my patient dental records to the office listed above.
The following information has been sent via :

E mail or hardcopy (Please circle which one)

Progress notes yes /no
X-rays yes / no
Lab reports yes / no
Other : _____

I understand that this transfer of information is essential for ensuring the continuity of dental care/treatment.

Patient or legal guardian signature: _____ Date: _____

Witness name: _____ Witness signature: _____

12, Dundonald Street
Hamilton HM 09`

Tel: 296 0990 Fax: 296 0991
Email: smiles@smilesinc.bm
Website: www.smilesinc.bm