

# CONFIDENT

## SMILES & IMPLANTS

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:

Confident Smiles & Implants – O'Fallon  
2683 Highway K  
O'Fallon, MO 63368

Phone: 636-978-9978

Fax: 636-978-9963

Email: [Office@ConfidentSmilesAndImplants.com](mailto:Office@ConfidentSmilesAndImplants.com)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Date of Birth