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

_____ _____
Signature Date

_____ _____
Printed Patient Name Date of Birth