

# 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  
4133 Mexico Road  
St. Peters, MO 63376

Phone: 636-447-6060

Fax: 636-447-4228

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

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