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

_____ _____
Signature Date

_____ _____
Printed Patient Name Date of Birth