SMILEORA DENTAL CARE
430 Enfield Street, Enfield CT
(860)265-7890
(877) ORA-DENT
FAX 860-265-7892
dentalcare@smileora.net

AUTHORIZATION FOR RELEASE OF MEDICAL/DENTAL RECORDS

TO: ____

____

____

PATIENT'S NAME: ____

DATE OF BIRTH: ____

SOCIAL SECURITY NO: ____

A request submitted with either this original or a photocopy of this original will authorize you, the above named dentist, to make available and furnish Dental Records including X-rays to:

Dr. Anil Mehta, SmileOra Dental Care, 430 Enfield street, Enfield Connecticut, 06082. Preferably, you may also email records to dentalcare@smileora.net

Thanking you in advance
Sincerely

SIGNATURE: ____

______________________________ ______________________________
NAME DATE