SMILE DESIGNS

Authorization for Release of Dental Records

Patient Name: _____ **DOB:** _____

Here by Authorize:

Doctor: _____

Dental office name: _____

Phone number: _____ **Fax:** _____

Email: _____

to release records concerning my dental health to:

Doctor: Stephanie Sandretti, DDS

Phone: (916) 532 - 1635

Email: Smile@GalleriaSmileDesigns.com

Office Address:

Galleria Smile Designs	**Sacramento Smile Designs**
508 Gibson Dr, #190	7501 Hospital Dr, #202
Roseville, CA 95678	Sacramento, CA 95823

Types of records request: X-rays, Dental Chart, Perio Chart and Treatment Plan

Signature: _____ **Date:** _____

Name: _____

Relationship: _____