Smith & Rockefeller FAMILY AND COSMETIC DENTISTRY

Christopher H. Smith, DMD
Van P. Rockefeller, DMD

DENTAL AND MEDICAL AUTHORIZATION RELEASE

I, _____ hereby authorize the office of Drs. Smith and Rockefeller to
(Print complete legal name)
release all my dental and/or medical information, records, and x-rays to the name and address listed below:

_____

_____

_____

I have requested the transfer of these records for the reason(s) listed below:

_____

Each family member 18 and older must sign this form before records can be released.

I hereby give authorization for release on:

This _____ day of _____ , 20 _____ .

By: _____
(Authorized signature of patient, parent of or legal guardian of patient of record)

_____	_____
Print name of patient	Signature (patient, parent or guardian)
_____	_____
Print name of patient	Signature (patient, parent or guardian)
_____	_____
Print name of patient	Signature (patient, parent or guardian)
_____	_____
Print name of patient	Signature (patient, parent or guardian)