SMALLWOOD
DENTAL SOLUTIONS

Medical Records and X-Ray Release Authorization

I hereby authorize and request you to release my most current x-rays, patient history, and patient chart

FROM:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

TO: **Smallwood Dental Solutions** at the above listed contact.

I understand that my records may not be available for immediate pickup or transfer and it may take up to one week to process this request to have my records released/transferred.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

Patient Name:_____ **Date of Birth**: _____

Address:_____

Phone:_____

Signature/Guardian Signature:_____ **Date**:_____