**Smiles for the Future**
**Pediatric Dentistry & Orthodontics**
**379 Naubuc Avenue**
**Glastonbury, CT 06033**
**Phone: 860-633-5246**
**Fax: 860-633-5249**

## *Authorization for Release of Dental Records and X-rays*

I, (print patient name with date of birth)_____, hereby authorize the doctors and staff of Smiles for the Future to release records or knowledge concerning my dental health to:

Full Dr. Name _____

Street Address _____

City, Zip Code _____

Practice telephone number _____

Please release the following copies to the above listed dental office:

**X-rays:** (Taken in the last 3 years unless otherwise specified).

**Specific dates:**_____

**Treatment Notes** (Visits for last 3 years unless otherwise specified.)

**Specific dates:**_____

Signed (patient or guardian name) _____Date:_____

Print name (patient or guardian name) _____