Geneva Smiles
477 S Third St Suite 142
Geneva IL 60134
Office 630.599.7095 E-Fax 630.888.2883216

Authorization for Release of Dental Records and X-rays

I, (print patient or guardian name) ______________________________, hereby authorize the doctors and staff of______________________________to release records or knowledge concerning my dental health to:

Full Dr. Name ______________________________
Street Address ______________________________
City, Zip Code ______________________________
Practice telephone number: ____________________
Fax number: ______________________

I specifically request that you release copies of:
current x-rays and current treatment notes

Signed (patient or guardian name) ______________________________

Printed name (patient or guardian name)______________________________

Please complete this form and fax it to 888.288.3216.