Smith & Meadows FAMILY AND COSMETIC DENTISTRY

Christopher H. Smith, DMD
Frederick J. Meadows, DDS
Van P. Rockefeller, DMD

DENTAL AND MEDICAL AUTHORIZATION RELEASE

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

____

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____

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)

1178 Grimes Bridge Road, Suite 100 Roswell, GA 30075 770-992-7550 www.SmithAndMeadows.com