POLISHED

DENTISTRY *for* COMPLETE HEALTH

On this date, _____, I, _____ hereby authorize

_____

(provider/office name)

to release my/my dependent's dental records and all protected health information including treatment completed, summaries of symptoms, prognosis, diagnosis, and treatment note. Please forward all information to:

Polished Dentistry
2958 Dougherty Ferry Road
St. Louis, MO 63122

Phone: 636-394-4275
Fax: 636-394-1188
Email: ContactUs@PolishedSmiles.com

_____ _____

Signature Date

_____ _____

Printed Patient Name Date of Birth