Smile Wonders
www.smilewonders.com
11790 Sunrise Valley Drive | Suite 105 • Reston, VA 20191
info@smilewonders.com
(571)350-3663

Patients 18 years of age are considered adults and therefore must request their own records.

Patient Name: _____ * _____ * ___ _____
Last | First | MI | Preferred Name

Address: _____ * _____
Address 1 | Address 2

_____ * ___ * ___-___ *
City | State | Zip Code

Phone: _____ * _____ _____ _____ **Best time to call:** _____
Home | Mobile | Work | Ext

Type of request: *

☐ Radiographs only - No charge ☐ Photographs ☐ Services rendered

Method of records release *

◯ Email ◯ Mail ◯ In-person pickup

Reason for request: *

☐ Collaboration with a recommended provider in the care team - No charge.

☐ Returning to a referring provider - No charge.

☐ Personal use

☐ Transfer to another provider/Second opinion, Email:_____

☐ ***I understand that:**
I have to allow a minimum of 3-5 business days for processing the request.
Authorizing the disclosure of this healthcare information is voluntary.
Once the information has been released according to the terms of this authorization, the information cannot be recalled.
Submission of this form is my acknowlegement of consent and signature.
This authorization is only applicable for services provided upto this date.
Any additional request for Release of Protected Health Information will require a separate authorization.

Authorization for the Release of Protected Health Information

☐ ***I understand that only legal guardian can request or consent to sharing patient records with another provider. Please provide relationship to patient:** _____

☐ ***I understand that there is a charge of $20 for the processing and preparation of patient records.**

Name on the Card: _____

Credit Card Number:_____ Exp Date:_____ CVV code____

Signature: _____

Response Date: ___/___/_____