T&CS
TOWN & COUNTRY
SMILES

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:

Town & Country Smiles
2821 N. Ballas Road Ste 160
St. Louis, MO 63131

Phone: 314-567-5477
Fax: 314-567-4804
Email: ContactUs@TownAndCountrySmiles.com

_____ _____
Signature Date

_____ _____
Printed Patient Name Date of Birth