

Request Records Release

To/ From:

Please send all records as individual jpeg images to:

Smiles@fairfielddentalassociates.com

Inclusive:

-Clinical X Rays

-Clinical notes

-Treatment Plans

-Prior Authorizations

I authorize the release of all dental and medical records relevant to dental treatment or copies of such and request that they are transferred to the above location as well as cc'd to myself at:

E-mail _____

Signature: _____

Date: _____

Please allow 7-10 business days for processing