Date: _____

I, _____, am requesting the release of my dental records/x-rays.

Please forward these items to the following address/ e-mail:

Smileworks

contact@smileworks.us

882 Whipple Road, Suite 401

Mt. Pleasant, SC 29464

(843) 654-7300

Fax: (843) 654- 7301

Patient Signature: _____

Parent Signature: _____ (If Patient is a Minor)