Records Release Form

I, _____, authorize Emerald Isle Smiles Dental Studio to request the following records from my previous dentist.

Previous Dentist: Name _____

Address_____

City _____

Phone _____

Fax _____

Please note that Emerald Isle Smiles Dental Studio is requesting the following records:

- All x-rays from the past five years
- All perio readings
- Recommended treatment and treatment plans

_____ _____

Signature of Patient/Parent/Guardian Date

*Note to patients: Please send this form back either by fax to: 252.354.4688 or scan and email to drmyers@aspidamail.com before your appointment.

*Note to doctor: Emerald Isle Smiles Dental Studio is a chartless office and would prefer that the above records be sent via email to drmyers@aspidamail.com.

Records may also be sent to the below address:
8914 Reed Drive
Suite C
Emerald Isle, NC 28594