Consent To Release / Request Dental Records

www.GreatSmilesAreHere.com *(925) 939-9177*

I, _____, do hereby consent and authorize _____ to disclose
(patient name) (previous dental /medical office)

To Dr. Mary Zarekari DMD information in my record, including current and previous dental records from other practitioners, hospitals and / or clinics which are part of my record.

My date of birth is _____, and my social security number is _____
(patient date of birth) (patient social security number)

This information is strictly for the purpose of identification.

I also consent to release of dental records by Mary Zarekari in the event any additional information is needed by insurance company or other providers.

Patient or guardian signature: _____

Print: _____

Relationship to patient: _____

Date: _____

Please send this to:

Mary Zarekari, DMD
1575 Treat Blvd, Suite 115
Walnut Creek, CA 94598
Fax: (925) 939-4807

If you have any questions please call our office: 925-939-9177

Copies of following records are specifically requested:

- ☐ Progress notes
- ☐ Letters /Records to/from specialist
- ☐ Periodontal charting
- ☐ Radiographs
- ☐ Medical History Forms