INCREDIBLE *Smiles*™

CONSENT TO RELEASE MEDICAL RECORDS

(FMX or Pano within 3-5 years
BWX within 1 year)

Records requested from: _____
Doctor

_____
City

_____
Phone Fax

_____
Last name First Name Middle Name

_____
Telephone Date of Birth

Please send the following records to:

Priya Uppal, DDS
4150 Darley Avenue, Suite 3
Boulder, CO 80305

** We prefer digital x-rays to be emailed by _____ to hello@incrediblesmiles.com*

I hereby grant permission for the release of these records.

_____ _____
Signature of guest Date