SUNSHINE
Creative Smiles

**Dr.Anala Panchumarti**

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

☐ I request and authorize Sunshine Creative Smiles, PL to release health care information of the patient named below to:

To:_____

Phone #:_____

Fax #:_____

Email:_____

☐ I request and authorize the release of all dental radiographs and information for the patient below to be sent to:

Sunshine Creative Smiles, PL

4714 N Armenia Ave Suite 102, Tampa Florida 33603

PH:813-876-1200 FAX: 813-870-2970

Email: Doctor@Sunshinecreativesmiles.com

THIS REQUEST APPLIES TO:

☐ Dental information relating to the following treatment, condition or specific dates of treatment

☐ Current Dental Radiographs

☐ Other: _____

PATIENT NAME:_____ DATE OF BIRTH:_____

I understand that my consent is required to release any healthcare information relating to testing, diagnosis and treatment.

Signature (Patient, Parent or Guardian) Date: