New England Dental

Family Dentistry • Se Habla Espanol • Falamos Portuguese

DENTAL RECORDS/X-RAYS RELEASE REQUEST

Date: ______________________________

To: ____

Address: ____

City: _________________________ State: ___________________ Zip: ___________________

I authorize the release of dental records/x-rays relevant to dental treatment, or copies of such, and request that they be transferred to the above address.

____________________________________ ____________________________________

Name of patient Signature of patient/parent or guardian

Danbury Location: 54 Main St., Suite F, Danbury, CT 06810 • Phone: 203-790-0111 Fax: 203-797-0822
Brookfield Location: 246 Federal Rd., Suite B-11, Brookfield, CT 06804 • Phone: 203-790-0111 Fax: 203-797-0822
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