



New England Dental

Family Dentistry • Se Habla Espanol • Falamos Portuguese

DENTAL RECORDS/X-RAYS RELEASE REQUEST

Date: _____

Patient Email Address: _____

Dentist Email Address: _____

To: _____

Address: _____

City: _____ State: _____ Zip: _____

Reason for Record Release: _____

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