NEW ENGLAND SMILES

RELEASE OF RECORDS FORM

I _____ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

_____

_____

_____

Email: _____

Name of Patient: _____

Date Of Birth: _____

Records being requested:

( ) Current Radiographs ( ) Dental Health Status

( ) Treatment Record ( ) Charts

Other:

_____

Records being requested: _____

_____ _____

Signature(Parent/Guardian if minor) Date

Address: 1168 Lakeview Ave, Dracut, MA 01826
Phone: (978) 957-7009
www.newenglandsmiles.com