cda cheshire dental associates

203-272-2729

RELEASE OF RECORDS

I, _____ hereby request and authorize

_____ Of _____

(Previous Dental Office Name) (Previous Dental Office Location)

To forward a copy of _____'s dental records to:

Dr. Jeffrey Bisson or Dr. Dane Fletcher by: EMAIL: image@smilesofcheshire.com (Jpeg) or Mail to 482 South Main Street, Cheshire CT 06410

_____

(Patient signature or Patient's Guardian signature)