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. Dane Fletcher, Dr. Julia Marrandino, Dr. Anna Kimberly or Dr. Leigha Milks by: EMAIL: image@smilesofcheshire.com (Jpeg) or Mail to 482 South Main Street, Cheshire CT 06410

_____
(Patient signature or Patient's Guardian signature)