



www.dentalwh.com
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F: 203-790-0831
care@dentalwh.com

_____/____

To _____

_____ Fax # _____

RELEASE OF DENTAL/MEDICAL RECORDS

I _____ D.O.B. _____ authorize the release of all my dental/medical records including x-rays, treatment notes and any additional information pertinent to my dental health to Dental Wellness & Health, PC.

Additionally, I authorize the release of the records as stated above for:

_____ D.O.B. _____ Relationship _____

_____ D.O.B. _____ Relationship _____

_____ D.O.B. _____ Relationship _____

_____ D.O.B. _____ Relationship _____

_____ D.O.B. _____ Relationship _____

All electronic records can be emailed to: care@dentalwh.com

Thank you

Patient signature