Dental Wellness and Health

www.dentalwh.com
P: 203-744-1814
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 _____.

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