DATE: ___________________________

TO:

Doctor:____

Phone#:____

Fax#:____

RE: ____
(PATIENT NAME)

DATE OF BIRTH____

This is to authorize the release of records for the above named to:

DeMartin Dental Associates, PC

69 Sherman Street
P.O. Box 671
Fairfield, CT 06824
Office #203-255-0468, Fax #203-259-3560

*** E-mail: demartindental@gmail.com**

***WE USE DEXIS ~ BUT CAN ACCEPT .JPG, PLEASE ATTACH DATES X-RAYS WERE TAKEN. THANK YOU!**

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(Signature of Patient or Parent/Guardian if Minor)