12 North Main St, Suite 101
West Hartford, CT 06107
(860) 236-4249

RECORDS RELEASE FORM

I, _____hereby authorize

(Previous Dentist's Name): _____to provide

WEST HARTFORD DENTAL GROUP with copies of my dental records with respect to any dental care and treatment that I have received.

I understand that the specific type of information to be disclosed includes a detailed report of examinations, treatment provided, x-rays and all other records which pertain to me.

This consent is effective until such date as I cancel this consent. I understand that the information obtained as a result of this consent may be used after the cancellation date.

(Patient Signature) _____

(Parent or legal guardian signature) _____

PATIENT (s) DATE OF BIRTH: _____

DATE: _____