**Dental Health & Wellness Boston**
FOR YOUR HEALTH, YOUR LOOKS AND YOUR LIFE

# Patient Release of Dental Records

I, _______________________________________________ Hereby authorize the release of a copy of my dental records, including radiographs.

Patient: _______________________________________________

Address: _______________________________________________

Phone Number: _______________________________________________

Date of Birth: _______________________________________________

Prior Name: _______________________________________________

From the office of: _______________________________________________

To the office of: _______________________________________________

Address: _______________________________________________

Phone Number: _______________________________________________

Email: _______________________________________________

Fax Number: _______________________________________________

Patient Signature: ________________________________

Print Name: ________________________________

Date: ________________________________

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