RELEASE AND REQUEST FOR TRANSFER OF RECORDS AND X-RAYS

Patient Name(s): _____ Date of Birth: _____

I hereby authorize the release of all records, x-rays, and treatment notes or copies of such from:

Dentist/Office Name: _____

Street Address: _____

City: _____ State: _____ Zip:_____

Office Phone: _____ Office Fax: _____

I hereby request that they be transferred to:

Colchester Dental Group, LLC
79A Norwich Avenue
Colchester, CT 06415

****Please email digital x-rays to: thecdg@sbcglobal.net**

Patient has appointment scheduled at our office on _____.

Please contact our office if you are unable to forward records/x-rays before scheduled appointment. Thank you.

_____ _____

Signature of Patient/Guardian Date