MODERN DENTISTRY of NEW ENGLAND

DENTAL RECORDS RELEASE FORM

I, ____ _____/_____/_______

Print Name Date

Herby request, and authorize the release of dental records most recent- FMX/Pano & Bwx, from the office of:

____

And request they be *transferred to*: Modern Dentistry of New England

EMAIL: care@moderndentistryne.com

OFFICE PHONE #: (860)582-4485 FAX #: (833)650-8864

Name of Patient:_________________________________ Date of Birth:____/____/________

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When transferring information to another dental office we only send current x-rays (bitewing x-rays, full mouth x-rays & Panorex) within the last 5 yrs.

By signing, I understand that the information released per this authorization, if re-disclosed by the recipient, is no longer protected by Sherif Gabr DDS/Modern Dentistry of New England

X ______________________________________ DATE: _________________

SIGNATURE OF PATIENT / LEGAL REP

If signed by a person other than the patient, complete the following: Individual is:

☐ parent* legal guardian ☐ legally incompetent

225 N. Main St. Bristol, CT. 06010

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