North Country Dental

NEW HAMPSHIRE'S DENTIST

RELEASE OF MEDICAL RECORDS

I, _____ DOB_____

Authorize: North Country Dental

22 Exchange St.

Gorham NH 03581

reception@ncdnh.com

Fax # 603-466-5791

To Disclose to:

_____

_____

___**X**___ Recent Radiographs

_____ Records pertaining to _____

Patient Signature: _____Date:_____

OR

Parent/Legal Guardian/Representative Signature:

_____Date:_____