North Country Dental

NEW HAMPSHIRE'S DENTIST

RELEASE OF MEDICAL RECORDS

I, _____ DOB_____

Authorize: North Country Dental

2936 White Mtn highway ste 2
Po Box 657
North Conway, NH 03860
conway@ncdnh.com
Fax # 603-733-5516

To Disclose to:

_____

_____

___**X**___ Recent Radiographs

_____ Records pertaining to _____

Patient Signature: _____Date:_____

OR

Parent/Legal Guardian/Representative Signature:

_____Date:_____