RELEASE OF MEDICAL RECORDS

I, ________________ DOB_______________

Authorize: ___________________________

____

To Disclose to: North Country Dental

22 Exchange St.

Gorham NH 03581

reception@ncdnh.com

Fax # 603-466-5791

___**X**___ Recent Radiographs

_______ Records pertaining to _______________

Patient Signature: ____Date:_______

OR

Parent/Legal Guardian/Representative Signature:

____Date:_______