RELEASE OF MEDICAL RECORDS

I, _________________________________ DOB_______________

Authorize: ____

____

To Disclose to:

North Country Dental
2936 White Mtn. Highway, Ste. 2
P.O. Box 657
North Conway, NH 03860
conway@ncdnh.com
Fax: 603-733-5516

___X___ Recent Radiographs

_______ Records pertaining to _______________

Patient Signature:____Date:_______

OR

Parent/Legal Guardian/Representative Signature:

____Date:_______