RECORDS RELEASE

To:_____

Address:_____

City, State, Zip:_____

Phone:_____

I hereby authorize the release of **ALL** my most recent x-rays and records or copies of such and request that they are transferred to:

West Hartford Family Dentistry
342 North Main Street Suite 300
West Hartford, CT 06117
860-233-0552

If most recent x-rays are digital please email to info@whfdentistry.com

Print Name & Date of Birth:_____

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Patient's Signature & Date:_____