New Hampshire Center *for* Comprehensive Dentistry

DENTAL RECORDS RELEASE FORM

I am authorizing the copy and release of the dental records and most recent radiographs of the following patients (please print):

Myself:_____ Date of Birth:_____

Dependent:_____ Date of Birth:_____

Dependent:_____ Date of Birth:_____

Dependent:_____ Date of Birth:_____

Dependent:_____ Date of Birth:_____

Dependent:_____ Date of Birth:_____

☐ I will pick up records

☐ Please email digital images and charting to the following email: info@NHCCD.com

☐ Please mail to the following address:

New Hampshire Center for Comprehensive Dentistry
71 Route 101 A
Amherst, NH 03031

_____
Print Name

_____ _____
Street Address Phone Number

_____
City, State, Zip

_____ _____
Signature Date