AUTHORIZATION FOR RELEASE OF DENTAL RECORDS

Patient Name: _____

Date of Birth: _____

I hereby authorize release of my Dental Records and any current / pertinent radiographs to Northwest Corner Dental Partners

_____ _____

Signature of Patient (or parent if minor) Date

Please e-mail digital records to: info@NWCDental.com

Please send hard copies to : Northwest Corner Dental Partners
55 Peck Road
Torrington, CT 06790