RECORDS RELEASE/REQUEST

TO: _____

ADDRESS:_____

CITY, STATE, ZIP:_____

TEL:_____ Email:_____

I hereby authorize the release of my records and x-rays and request that they be sent to:

Orange Blossom Dental
489 Main Street Suite B
Groton, MA 01450

frontdesk@orangeblossomdental.com

PRINT NAME OF PATIENT:_____

DATE OF BIRTH:_____

PATIENT'S SIGNATURE:_____

DATE:_____

BRIEF REASON FOR TRANSFER:

_____