RECORDS REQUEST

I _____ D.O.B._____

Hereby request and authorize that you release to:

MICHAEL DENTAL OF CLINTON, LLC
37 Commerce Street
Clinton, CT 06413
860-669-5777

Email: michaeldentalclinton@gmail.com

A copy of my medical and/or dental records. This shall include x-rays (most recent FMX or PAN and most recent BWX), and any necessary treatment notes, records, medical reports and office notes.

Please note: HIPPA health information privacy laws state that email and/or fax may not be the most secure way to transfer records, however; I authorize the records transfer.

Patient Signature:_____ Date:_____