AUTHORIZATION TO RELEASE DENTAL RECORDS TO:

DRS SCANNELL AND HOLLINGER, INC.
79 MAPLE STREET
EAST LONGMEADOW, MA 01028
PHONE# 413-525-6821 FAX# 413-525-5280
EMAIL: OFFICE@SCANNELLANDHOLLINGER.COM

Name of Patient: ________________________________ Date of Birth: _________________________

I, ____ (patient/guardian) hereby authorize the release of my dental records from:

Name of Dental Practice: ____

Address:____

Phone:______________________ Fax:______________________ Email:__________________________

Check all that applies:

□ Xrays □ Charts □ Notes

Please send my records via. Email / Mail / Fax (Check One) to the address given below:

Email: ____
Address:____
Fax:____

Signature of patient/guardian____

Printed Name: ____

Date: ____

Please allow 5 working days from the time we receive this document to process your request.