AUTHORIZATION TO RELEASE DENTAL RECORDS TO:

Maple Dental Associates, PC.
79 MAPLE STREET
EAST LONGMEADOW, MA 01028
PHONE# 413-525-6821 FAX# 413-525-5280
EMAIL: office@mapleda.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.