Bridgeworks Family Dental Center
115 Bridge Street * Groton, CT 06340
Phone (860)446-8744* Fax (860)448-3780

REQUEST FOR RELEASE OF RECORD(S)

Patient(s) Name:_____

DOB:_____

I hereby authorize the release of dental x-rays or information concering the above named patient(s) from:

Doctor's/Office Names:_____

Address:_____

Phone Number:_____ Fax Number:_____

Please Release To :

_____

_____

_____

_____

Signature:_____
(Patient or persons authorized to consent for patient)

Date:_____

Digital x-rays can be emailed to bridgeworksfdc@yahoo.com