Dental Designs
OF NEW ENGLAND

PATIENT AUTHORIZATION
TO RELEASE CONFIDENTIAL INFORMATION

Patient Name(s): _____

Date of Birth: _____

Home Address: _____

Appointment Date at Dental Designs of New England (if applicable): _____

I hereby request and authorize _____ *(Dental Office)* to disclose and provide legible copies of any and all clinical treatment records and information, including updated Radiographs (xrays).

Email to:
smile@dentaldesignsofnewengland.com

or Mail to:
Dental Designs of New England
ATTN: New Patient Documents
7 Continental Blvd. Suite E
Merrimack, NH 03054

Signature: _____(Patient or Parent/Guardian)

Today's Date: _____