

I \_\_\_\_\_:  
(Please print)

Authorize the release of my dental records, including copies of radiographs,  
treatment records and medical history for patient:

\_\_\_\_\_  
To be sent to:

The Belmont Dental Group  
57 Concord Avenue  
Belmont, MA 02478

If you are able to provide digital x-rays please e-mail to:  
[contactus@belmontdental.com](mailto:contactus@belmontdental.com)

\_\_\_\_\_  
Patient signature or Legal Guardian signature

\_\_\_\_\_  
Date