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

_____ _____
Patient signature or Legal Guardian signature Date