

Conway Oral Healthcare
51-A Washington Street
Conway, NH 03818-6044
(603) 447-1999

RELEASE OF RECORDS

Please provide copies of all my dental treatment records, including diagnostic x-rays and any other materials and notes. I agree to accept copies and to pay reasonable fees for such copies.

___ Copies should be sent to the dental office listed below

___ Copies should be sent directly to me

Name _____

Address _____

Patient Name: _____

Patient Signature _____ Date _____
(Parent if Minor)

Witness _____