DATE: _____

TO:

Doctor name:_____

Phone#:_____

Fax#:_____

RE: _____
(PATIENT NAME)

DATE OF BIRTH_____

This is to authorize the release of records for the above named to:

DeMartin Dental Associates, PC
69 Sherman Street
P.O. Box 671
Fairfield, CT 06824
#203-255-0468
*** E-mail: demartindental@gmail.com**

_____

(Signature of Patient or Parent/Guardian if Minor)