300 Crown Colony Drive Ste 203 Quincy, MA 02169
(p): 617-472-5437 (f): 617-472-2580 (e): kids@greaterbostonsmiles.com

Records Release

I hereby authorize and request you to release to:

_____

_____

_____

The complete dental records, including all x-rays, in your possession concerning the treatment of:

Patient(s) Name	D.O.B.
_____	_____
_____	_____
_____	_____

Reason for transfer:

_____

Signature: _____

Relationship: _____

Date: _____