NEW LONDON
FAMILY DENTISTRY

Please fill out this form and then send it to your former dentist

Authorization for Release of Dental Records

Name of patient: _____

Patient's DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional family members to be included:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

I, (print patient or guardian name) _____, hereby authorize the release of dental records to:

Digital records (PREFERRED):

admin2@newlondondentists.com

Paper or film copies:

Christopher Clemens, DMD
P.O. Box 265
New London, NH 03257
(603) 526-6655

Signed (patient or guardian signature): _____

Date: _____