newleaf
family dental

RECORDS RELEASE FORM

I HEREBY REQUEST AND AUTHORIZE

_____ OF
(PREVIOUS DENTAL OFFICE NAME)

_____
(PREVIOUS DENTAL OFFICE LOCATION)

TO FORWARD A COPY OF THE DENTAL RECORDS FOR

_____ DOB: _____ TO
(NAME OF PATIENT)

DR. GREGORY BEMIS AT NEW LEAF FAMILY DENTAL BY:

FAX TO 203-250-0193 or
MAIL TO 314 WEST MAIN ST. CHESHIRE CT 06410 or
SECURE EMAIL TO frontdesk@newleaffamilydental.com
(X-Rays in Dexis format please)

_____
(*SIGNATURE OF PATIENT OR PATIENT'S GUARDIAN*)

_____
(PRINTED PATIENT NAME OR GUARDIAN NAME)