



**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](mailto:frontdesk@newleaffamilydental.com)  
(X-Rays in Dexis format please)

\_\_\_\_\_  
(SIGNATURE OF PATIENT OR PATIENT'S GUARDIAN)

\_\_\_\_\_  
(PRINTED PATIENT NAME OR GUARDIAN NAME)



314 West Main St  
Cheshire, CT 06410

PHONE 203-250-3446  
FAX 203-250-0193  
EMAIL [frontdesk@newleaffamilydental.com](mailto:frontdesk@newleaffamilydental.com)  
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