Plymouth General Dentistry, P.L.L.C.
65 Highland Street
Plymouth, NH 03264
603 536-4301
603 536-1984 Fax
pgdentistry@roadrunner.com

AUTHORIZATION TO RELEASE DENTAL INFORMATION

Date:

I hereby authorize and request that you:

Former Dentist ____

Address ____

City ________________________ State _______ Zip _______

release and deliver to Plymouth General Dentistry all my dental records, charts, files, prognoses reports, x-rays, clinical records and such other information relative to my dental condition or my treatment at any time provided to me, to the extent said information is available within your possession, as well as those of any family member listed. You are further requested not to disclose any information concerning my or my family member's past or present medical condition to any other person without my express written permission.

Thank you for your assistance.

________________________ (Print Name)

________________________ (Sign Name)

________________________ (Address)

________________________ (City, State, Zip)

________________________ (Additional Family Member)

________________________ (Additional Family Member)

________________________ (Additional Family Member)

________________________ (Additional Family Member)