Request for Release of Dental Records

Dr. Teddi Olszewski, DMD
Northampton Family & Cosmetic Dentistry
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Northampton, MA 01060
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413-584-2902 * Fax 413-586-9904

I, _____, hereby grant permission to
(Print patient name) (Date of birth)

_____
(Previous dentist's name)

_____
(Previous dentist's address & telephone number)

to release my dental health records -

Diagnostic **Copy of Dental X-rays** ***(individual files preferred!)*** ******
Treatment Notes
and
Periodontal Charting

- directly to (** *email/digital format preferred, if applicable***):

Dr. Teddi Olszewski, DMD
Northampton Family & Cosmetic Dentistry
264 Elm Street
Northampton, MA 01060
admin@enjoyyoursmile.com

Signature: _____ **Date:** _____
(*If patient is a minor, parent or guardian must sign*)

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